teoria polityki 7 | 2023 s. 215–230
doi: 10.4467/25440845TP.23.011.17524
www.ejournals.eu/TP

https://orcid.org/0000-0001-9501-2693
Marta Hoffmann
Jagiellonian University

The Immortal Life of Political Distrust: The Case of Vaccine Hesitancy among Black Population in the United States

Abstract: In her famous book, *The Immortal Life of Henrietta Lacks*, Rebecca Skloot describes not only scientific importance of using HeLa cells in biomedical research, but also the fact that the cells were obtained from Henrietta without her knowledge nor consent. Because the Lacks family was Black the case is repeatedly described as an example of 'Medical Apartheid' (Batelaan, 2021). 70 years after Lacks' death the COVID-19 pandemic reveals that vaccine hesitancy among Black communities in the US may have political roots dating back to slavery. According to Quinn et al., only 40% of Black adults were ready to be vaccinated at the beginning of 2021 (Padamsee et al., 2022) and death rates from COVID-19 are still very high among these groups (Ajasa, 2021). As some scholars argue, the tendency may result from political distrust of Black groups towards official public health measures against the pandemic (Woko, Siegel, Hornik, 2020; Restrepo, Krouse, 2022). Therefore, public health response regarding vaccinations becomes an important field of non-institutional politics where social distrust towards this medical procedure mirrors political distrust of Black communities towards the government. The paper explores the main features of anti-vaccinal movement among Black population in the US and argues that during the COVID-19 pandemic the field of public health may be more politically-sensitive than it had ever been before.

Keywords: Medical Apartheid, vaccine hesitancy, COVID-19 pandemic, public health policy, discrimination, Black population

Introduction

Scholars from social and political sciences may not be aware of the importance of the HeLa cells, but representatives of biochemistry and immunology very well know that without them many scientific breakthroughs would not have been possible. It is necessary to mention that at least two Nobel prizes were awarded for research involving the HeLa cells (BSI, 2022). Extracted in 1951 from Henrietta Lang, a 31-year old Black American suffering from cervical cancer, they are still in use in almost all laboratories in the world due to the fact they continually duplicate and thus, are often described as 'immortal' (BSI, 2022; Stump, 2014, pp. 127–130). Social scientists have also reasons to be interested in the most popular cell line, however. Not only the cells were extracted without her knowledge or consent, but also they were used in many research projects after her premature death (Hoberman, 2016, pp. 12–18). The fact that Henrietta was a Black woman and the vast majority of research was conducted by White males only gives the issue additional piquancy (Gill, Erevelles, 2017, pp. 123–129). After lengthy legal battle led by Lack's children her name became recognized worldwide and the issue of involving people of colour in medical experiments in the United States has prompted many socio-political studies and attracted much of the public attention which was even more inflated after Lack's biography entitled *The Immortal Life of Henrietta Lacks* was published in 2010. In the article I argue that Lack's case is an important symbol of political inequalities which became apparent in the most intimate area of policy which is public health. Horrible medical experiments in death camps during the Second World War, eugenic policy in Sweden or using psychiatric hospitals as a means of isolating political opposition in the USSR are only a few examples of dangerous liaisons between politics and medicine. Now, after public denunciation of Nazi's war crimes and the fall of the USSR it may seem that medicine and public health have been one of the most politically neutral aspects of social reality. Nothing can be further from truth and the example of health care system for the Black citizens in the USA vividly illustrates this fact. The so called 'structural racism' can be observable at all levels of public health policy regardless of geographical location of Black community (Bailey et al., 2017, pp. 1453–1463). Unfortunately, during the COVID-19 pandemic the health situation of the Blacks not only went from bad to worse, but also resulted in increased vaccine hesitancy within these groups (Hamel et al., 2021). Intrinsic racial inequalities and the vicious circle of poverty and disease among the poorest groups of Americans have been so obvious that the idea of 'Medical Apartheid' has emerged. The aim of the article is to present this concept and explain its relevance to the health situation among the Black population in America.

Political background of Henrietta Lacks' case

In order to explain the idea of 'Medical Apartheid' it is necessary to bear in mind that Apartheid was a system introduced in the South Africa in the 1950s, whose aim was to separate White and Black populations with all the political privileges going to the former. This leads us to the most obvious feature of the 'Medical Apartheid' which is extremely unequal distribution of public goods based on race (Brooks, Smith, Anderson, 1991, pp. 2746–2749; Golub et al., 2011, pp. 317–320). Although it was the South Africa where the idea of Apartheid resonated the most, the United States were not free from this 'colonial sin'. The lengthy battle for political rights of the Blacks has long history and its detailed description is beyond the purpose of this article. It is necessary to mention that although the issue seemed to be successfully resolved, recent incidents of recurrent violence against people of colour in America confirm that the problem of racism is far from being tackled (Jamison, Quinn, Freimuth, 2019, pp. 87–90; Laurencin, Walker, 2020, pp. 9–10).

One of the most widely known examples of that tendency is the case of Tuskegee Syphilis Study conducted between 1932 and 1972 in which around 600 Black males were involved in the study of untreated syphilis without their knowledge or consent (Alsan, Wanamaker, 2018, pp. 407–455; Laws, 2018, pp. 408–419; Batelaan, 2021, pp. 1–6). The most disturbing fact was that doctors who were conducting the research were not interested in treatment of suffering men. Instead, they left them without almost any healthcare in order to observe the development of the disease and summarize the conclusions in a series of articles (Frazier, 2020, pp. 280–296; Laws, 2018, pp. 408–410). Later on, this knowledge was used to design therapies against syphilis in White males (Alsan, Wanamaker, 2018, pp. 407–455). 50 years after the scandal was discovered the Tuskegee Study has still been portrayed as one of the most outrageous examples of using medicine as a tool of maintaining political inequalities in the USA (Callaghan et al., 2021, pp. 1–5). It is not a coincidence that the study was taking place at the same time when racial segregation was a part of everyday life and when Black population was deprecated at all political levels. People who were Black did not have voting rights until 1965 nor the access to well paid jobs and universities. Usually they lived in the poorest districts of big cities and died prematurely as Henrietta Lacks (Gill, Erevelles, 2017, pp. 123–137; Robillard, Annang, Buchanan, 2015, pp. 18–23). On the one hand not having an access to good healthcare was a result of a weak political position of the Blacks, but on the other, poor health condition of the Black population as well as premature death further compromised their position in the United States. In this sense, the Tuskegee Study was a clear example of double moral standards presented by White doctors towards Black patients (Hoberman, 2016, pp. 12–18).

The case of Henrietta Lacks, which took place at the same time when the Tuskegee Study was conducted, is a bit different, however. Contrary to the human subjects from the latter case, the 31-year-old woman was treated at the gynaecological ward in the Johns Hopkins Hospital (Stump, 2014, pp. 127–131) against cervical cancer when the cell lines were extracted from her body. Instrumental treatment of her disease was not so obvious in this case and scientists could argue that the new cell line was only a 'by product' of the last stage of her battle against cancer. Nevertheless, for many years they had not mentioned how they obtained the cells (Gill, Erevelles, 2017, pp. 123–137; Skloot, 2010, pp. 152–179). Thus, the tragedy of a young woman which stood behind many scientific discoveries of that time for quite a long time was hidden from the public because Henrietta Lacks came from politically underprivileged group. This is the first aspect of political background of the story, namely, dehumanization of Black patients who were, more or less directly, treated as objects of scientific research. Second aspect is a structural one since Henrietta was in a hospital in Boston where many Black females got treatment which was not on the highest level (Gill, Erevelles, 2017, pp. 123–129). Third aspect of the problem is more general since, as one scholar pointed out, in the Lacks' case 'No laws were broken because protections developed since did not exist' (Stump, 2014, p. 128). Bioethical considerations about scientific research were still at the very early stage of development (Hoberman, 2016, pp. 12–18). The fact that only one scholar asked Dr. Gey about patient's consent in a response to his scientific report is quite telling (Skloot, 2010, pp. 152–190; Stump, 2014, pp. 127–131). Since then bioethical considerations have been an intrinsic feature of nowadays research but it is necessary to acknowledge that the breach of Lacks' rights took place in a general legal limbo in that area. Fourth aspect is related to further consequences of the HeLa cells issue. Even after violating of moral standards was revealed, the Lacks' family for considerably long time was leading a legal battle for acknowledging Henrietta's input in the development of modern anti-cancer therapies without huge success (Gill, Erevelles, 2017, pp. 123–137). Only after Rebecca Skloot's book was published, the case of Henrietta Lacks attracted public's attention. This means that even if the case was well known within medical environment,[1] Black groups were still separated from fruitful effects of the use of HeLa cells due to their underprivileged political situation.

Since the 1970s the health situation of the Blacks has not improved, however. Even if health rights of the people of colour in America have never been at the forefront of political agenda, it was Dr. Martin Luther King who said that: "Of all the forms of inequality, injustice in health care is the most shocking and inhumane" (Johnson, 2017, p. 1108). The lack of available places in hospitals, too short time of medical appointments, overcrowded medical facilities and too expensive pharmaceuticals and therapies were, unfortunately, challenges that followed another decades of the twentieth century regarding public healthcare for Black population in the US (Cortese, 2003, pp. 110–122; Brooks, Smith, Anderson, 1991, pp. 2746–2749). It is necessary to mention that religious groups and churches took the initiative and for many years performed advocacy role regarding poor health situation within this group. The phenomenon of high vaccine hesitancy among Black Americans observed during the COVID-19 pandemic can be perceived as a result of the issues mentioned above (Jamison, 2020). The

---

[1] The name of HeLa cell line was introduced in 1971.

fact that compared to other groups in the USA their health indicators are considerably low has encourage some scholars and journalists to use the term 'Medical Apartheid' (Golub et al., 2011, pp. 317–325). But what does the concept mean?

Medical Apartheid as a descriptive concept for public health hesitancy among the Blacks

The idea of 'Medical Apartheid' gained much public attention after Harriet Washington's book entitled *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* was published in 2007 (Innis, 2022). In her book Washington traces multiple examples of medical abuse of Black patients from White doctors and medical officers. The book not only describes some unsettling details of medical experimentation on Blacks, but also tries to convince the reader that the phenomenon has not disappeared with the beginning of the 21st century (Washington, 2008, pp. 189–299). Washington used the term which had appeared for the first time more than a decade before her publication was released. Prof. Charles Rossmann used this word for the first time in 1988 while describing institutional conflict between Canadian and non-Canadian doctors (Rossmann, 1988, p. 492). But it was Durado Brooks and his colleagues who used the idea in order to label the health situation of Black population in America in 1991 (Brooks, Smith, Anderson, 1991, pp. 2746–2749). He introduced a very useful concept which, on the one hand, derived from cultural memory related to the Apartheid policy and adapted it to the much neglected field of public health on the other. Bearing in mind that public health sector for quite a long time was treated as an additional field of policy comparing to much more 'serious' areas such as economic growth, financial stability, security or social policy, to name a few. Adapting such an emotionally-packed word to the field in which racial prejudices are so deeply rooted was a courageous move in the debate on actual health situation of the poorest groups within the American society.

Due to the fact that the 'Medical Apartheid' term has been often used as a catchy word for journalists and scholars alike, it is high time to explain it regarding several categories. From literature review it is clear that the idea is very complex, so I divided it in several aspects. These are: systemic background, institutional duality, unequal effects of healthcare and political distrust.

The systemic background means the main rationale which stands behind the organization of public healthcare services in the US. From the very beginning it was clear that the 'Medical Apartheid' idea assumed duality between healthcare which is available to rich segments of the American society and that which is a 'gold standard' for the underprivileged among whom the Blacks are the majority (Peterson-Besse et al., 2014, pp. S51–S63; Tikkanen et al., 2017, pp. 460–465). The central feature which differentiates American citizens between these two categories is the type of insurance. Those who are not insured do not have an access to any form of health care with the exception of initiatives which are led by charitable foundations (Tikkanen et al., 2017, pp. 460–469; Chandler, 2010, pp. 915–931). Thus, the major division lies between those who are privately insured and those who are covered by national programme called Medicaid. Whereas the former have an access better medical facilities and private doctors due to the fact that their employers pay for health insurance, citizens covered by Medicaid scheme often spend many hours in overcrowded medical offices waiting for their appointment while their primary doctors often change the place of work which means that building a deep doctor-patient relation is quite challenging (Cortese, 2003, pp. 110–122; Golub et al., 2011, pp. 317–325; Batelaan, 2021, pp. 1–8). Critics often highlight the fact that hospitals which take part in the Medicaid programme are sometimes very far away from the underserved areas, that many medical procedures are too expensive to be covered by the Medicaid programme and that doctors cannot pay much attention to their patients if their number is too high (Peterson-Besse et al., 2014, pp. S51–S63). Obviously, being covered by the Medicaid scheme means that a person is not employed or that his/her income is very low which are not rare features among the Black population. Thus, the basic concept of healthcare in the USA assumes duality which often overlaps with racial and economic divisions within American society.

A direct consequence of duality described above is dual dynamics of public health goods' distribution. When a person is covered by a private insurance scheme he/she has an access to private clinics which are close, well-equipped and having many highly specialized services and procedures at their disposal. Conversely, those who are not insured including numerous Black American citizens have to deal with long queues mentioned above, many bureaucratic procedures and busy medical staff, especially doctors and nurses (Hamel et al., 2021, pp. 22–29). This often leads to a situation in which the ill just withdraw from the queue or skip their appointments (Chandler, 2010, pp. 915–931). As a result their health condition worsens and they come back to primary doctors either when it is too late to help them or when proposed treatment demands using complicated medical procedures which are not available for them (Golub et al., 2011, pp. 317–321). The dual standards of healthcare is clearly visible also from doctors' point of view. In the private scheme they have regular contact with patients and they can monitor their state of health for many years, whereas in the public scheme they even do not know their patients since time gap between appointments is too big to build a relation which is full of trust (Cortese, 2003, pp. 110–122). Also the fact that the number of patients is so high impacts their engagement in the process of treatment. And even if a person suffering from a disease receives proper treatment, the cost of pharmaceuticals and drugs is often too high and they cannot afford it (Chandler, 2010, pp. 921–931). This vicious circle of poverty and ill health continues as we observe another aspect of the problem.

Both factors contribute to different health situation of the publicly and the privately insured which to some extent corresponds with health situation of the Whites and Blacks. Nowadays, more and more people suffer from the so called chronic conditions and those resulting from non-healthy lifestyle. High prevalence of cardiac diseases, obesity, neurodegenerative problems and mental health issues became one of the most characteristic features of modern societies (WHO, 2022). New opportunities offered by medicine also strengthened phenomenon which is labelled as 'medicalization of everyday life', that is, changing socio-political problems into treatable conditions (Conrad, 2007). This, in turn, further amplified human reliance on medicine and pharmaceuticals. In this situation the contrast between both sides of the so called 'Medical Apartheid' seems to be even more staggering. Whereas privately insured have many opportunities to manage their health and choose different forms of therapies, those who rely on the Medicaid scheme do not have similar choice. In effect, almost all statistical data indicates that the prevalence of chronic health conditions among Black population in the US is much higher than in case of other racial groups: the Blacks have much shorter lifespan, more often die from preventable diseases, have more chronic conditions and higher rate of premature deaths (Niño, Hearne, Cai, 2021, pp. 1–8; Tai et al., 2021, pp. 703–306; Kricorian, Turner, 2021, p. 1). Even if the concept of Apartheid may not be convincing regarding the area of public health, undeniably, the American model of healthcare, which is based on two types of insurance, results in stark differences between a group which have many opportunities of managing their health conditions and a group which is a passive subject of global health trends (such as high prevalence of chronic and non-communicable diseases).

The last aspect of the model of 'Medical Apartheid' focuses on the lack of trust of Black groups towards public health governance in the US. This is a final consequence of all factors described above. In case of South African Apartheid it was clear that Black citizens were entirely excluded from the government and could have been only passive observers of political process taking place somewhere above them (Tikkanen et al., 2017, pp. 460–476). In case of 'Medical Apartheid' the lack of public investment in health, bad economic situation of the Blacks and smaller than average number of Black doctors result in distrust towards public health authorities and seeking other, alternative ways of treatment. The use of Traditional and Complementary Medicine among the Blacks only confirms this tendency (Chandler, 2010, pp. 915–931; Laws, 2018, pp. 408–419). Also, statistical data indicates that the Black groups do not feel public support regarding healthcare which further separates them from mainstream medicine (Hamel et al., 2021, pp. 11–29). The availability of health information in the Internet and social media is another factor which contributes to the fact that the ways of public healthcare and Black groups are growing apart (Woko, Siegel, Hornik, 2020, pp. 819–820). Unfortunately, such circumstances foster the rise of conspiracy theories which accentuate a motive of medical abuse of the Blacks presented also in popular culture as in case of *Get Out* movie from 2017. These tendencies correspond with strengthening many anti-vaccinal movements which are often strongly supported by those who feel disappointed with public healthcare (Dubé, Vivion, MacDonald, 2015, pp. 99–117). The case of vaccine hesitancy among the Blacks during the COVID-19 pandemic vividly illustrates this.

The case of vaccine hesitancy among the Blacks during the COVID-19 pandemic

The COVID-19 pandemic, which has become a truly global health crisis, showed that the trust in government, or at least, in public health agencies is a key factor to successful handling the challenge. Obviously, regardless of the type of public health system, the pandemic had many victims in every region of the world. As of April 2021 2.8 million people died from COVID-19 and around 132 million were infected (Viswanath et al., 2021, pp. 1–10). After anti-COVID vaccines were introduced the dynamics of the spread of the disease slowed down (Hogan, Pardi, 2022, pp. 17–29). From that time it turned out that the vast majority of those who died from COVID were not vaccinated and the public debate on vaccine hesitancy intensified. Those who were not sure whether they will get vaccinated in the future often underlined that the vaccine has been introduced too early (Bogart et al., 2021, pp. 18–24; Laurencin, 2021, pp. 543–546; Restrepo, Krouse, 2022, pp. 1147–1160). Another conclusion was that the Black Americans was the most hesitant group regarding the vaccines as compared to other groups within American society since more than one-third of the participants of a panel survey conducted by RAND clearly stated that they did not want to be vaccinated (Bogart et al., 2021, pp. 3–5). According to the Pew Research Center in September 2020 only 32% of Black adults expressed their wish to be vaccinated if effective vaccines were available (Woko, Siegel, Hornik, 2020, p. 819). Interestingly, this did not lead to the emergence of a new Black anti-vaccinal movement. Rather, they expressed distrust which, according to some scholars, was somehow related to the cultural memory of the Tuskegee Study and Henrietta Lacks' case (Frazier, 2020, pp. 280–296; Kricorian, Turner, 2021, p. 1). Nevertheless the phenomenon of vaccine hesitancy among the Blacks in the US shares many similarities with the model of 'Medical Apartheid' described in the previous chapter.

Regarding systemic background the anti-vaccinal stance of the Blacks has the same roots as the described concept since the majority of those who died from COVID-19 as well as those who did not believe in vaccines' effectiveness were either uninsured or insured publicly. Many Black opponents of anti-COVID vaccines claim that their stance results from 'structural racism' or 'medical racism' they had experienced before (Restrepo, Krause, 2022, pp. 1147–1160; Schmidt et al., 2020, pp. 2023–2024). In this sense, vaccine hesitancy is a consequence of a basic feature of health system in the United States which is duality of health care. Consequently, those who feel that their basic health needs are not met due to the negative aspects of a public pillar of healthcare in the United States simply do not trust the federal vaccine campaigns (Batelaan, 2021, pp. 1–14). The Blacks are especially hesitant about very short time in which the vaccine was ready and this prompts them to assume that the 'real' purpose of vaccination campaigns is testing the efficacy of vaccines in human subjects (Padamsee et al., 2022, pp. 1–12; Bogart et al., 2021, pp. 6–11). It seems that the cultural memory of the Tuskegee study is still very deeply rooted in perception of public health of Black Americans (Frazier, 2020, pp. 280–296; Laws, 2018, pp. 408–419; Woko, Siegel, Hornik, 2020, pp. 819–826). The lack of knowledge about the new coronavirus as well as about the process of vaccine manufacturing may have well contributed to this approach. Clearly, according to them the healthcare reality is divided between those who are treated as objects of involuntary testing and all knowledge obtained in this process is hidden from them and those who are treated by medical officers as subjects and thus benefit from this knowledge (Padamsee et al., 2022, pp. 1–12). Interviews with vaccine-hesitant Black Americans also indicate that often those who believe that administering anti-COVID vaccines may be a part of medical experiment also agree with the statement that if the vaccines were tested longer, they would sign up for vaccination (Bogart et al., 2021, p. 6; Woko, Siegel, Hornik, 2020, pp. 819–826) which confirms that an early phase of distributing anti-COVID vaccines is treated by some groups as an 'experimental phase' in which hesitant Black American do not want to partake in.

The institutional duality aspect in the 'Medical Apartheid' model focuses on actual performance of health system in the US. In many countries anti-COVID vaccines were administered by health government and citizens could get vaccinated in medical facilities. In case of Black Americans it means that even if they were going to be vaccinated, they had to visit the same places in which some of them meet with discriminatory practices (Padamsee et al., 2022, pp. 1–12). Inaccessibility of patient-oriented health care could have also contributed to vaccine hesitancy among the Blacks (Laurencin, 2021, pp. 543–546). Another aspect of the problem is low number of Black doctors and medical staff in hospitals and medical offices (Robillard, Annang, Buchanan, 2015, pp. 18–23). As we can observe, the lack of trust in health care system still corresponds with many racial prejudices. Although in the wake of the COVID-19 pandemic, when so many people declared their trust in health professionals, the fact that in the eyes of some Black Americans doctors are ‘a part of political establishment’ is quite telling (Jamison, Quinn, Freimuth, 2019, pp. 88–92). Interestingly, contrary to the initial stance of President Trump who tried to ignore the challenge, vaccine hesitancy did not correspond to disbelief in the pandemic itself which differentiates hesitant Black American groups from typical anti-vaccinal movements which often deny the COVID-19 disease (Callaghan et al., 2021, pp. 1–5; Woko, Siegel, Hornik, 2020, pp. 819–820). Thus, we can assume that even if they recognize the scale of the pandemic, they do not have trust in public health measures aimed at effective management of the problem (Padamsee et al., 2022, pp. 1–12). Another factor that may have been important in vaccine hesitancy was the phenomenon known as ‘infodemic’, that is a great deal of information on the pandemic which circulated in the Internet and were rarely true and reliable (Dhawan et al., 2021, pp. 799–808). Because of the perceived exclusiveness of health care system and medical knowledge in general, many Blacks were looking for information on the COVID-19 in social media which further isolated them from those who got vaccinated or, at least, had an impact in delaying the moment of vaccination (Bogart et al., 2021, p. 7; Callaghan et al., 2021, pp. 1–5). It is necessary to add that, indeed, public communication on vaccines in the USA may have sometimes seemed to be non-coherent regarding the fact that on the one hand citizens were encouraged to get the vaccine and follow social distancing rules and on the other they were stuck in long queues staying close to each other and waiting for vaccination. Some vaccine-hesitant Black Americans could also argue that they simply did not feel like visiting medical offices where they could meet with discriminatory behaviour (Padamsee et al., 2022, pp. 1–12). Summing up the argument, it seems that since vaccines were distributed via the same channels which, according to some Black Americans, isolated the White rich from the Black poor then vaccine hesitancy among the latter is only a logical consequence of the norms ruling the health care system in the USA.

Third aspect of the ‘Medical Apartheid’ idea is related to the consequences of the state of matters described above. As a consequence of vaccine hesitancy, Black Americans had the highest level of infections, death rates from COVID-19 and COVID-related health problems as compared to other racial groups (Tai et al., 2021, pp. 703–306; Padamsee et al., 2022, pp. 1–12). More than 50 thousand Black Americans have died from COVID (Kricorian, Turner, 2021, p. 1), whereas the risk for being infected among them is as high as 110% compared to the Whites (CDC, 2022) This means that, similarly to general health situation of the Blacks, the vaccine hesitancy resulted in worse health rates within Black communities as compared to the others. Those who had COVID were again admitted to the overcrowded hospitals in which, due to the huge number of patients, could not expect individualized care which further strengthened the feeling of racial abuse. Bearing in mind these numbers, one may ask what were the reasons for such deep vaccine hesitancy among the Blacks. In this case the idea of 'Medical Apartheid' offers some explanation which is partially based on cultural memory shaped by the Tuskegee and Lacks' cases (Jamison, Quinn, Freimuth, 2019, pp. 90–92; Kricorian, Turner, 2021, pp. 1–14).

The last aspect of the idea which is political distrust is also mirrored in vaccine-hesitant stance of the Blacks who often expressed their disappointment with political leaders. As one of Black Americans put this:

> All of a sudden a country that has literally kept a foot on our necks for years, and even during a pandemic has shown that it has no interest in collectively supporting us as human beings or as a people of colour, to put my life and my family's lives in your hands, to trust that you want to suddenly give me a vaccine that's going to save us (…) am I willing to gamble that they care this time? (Ajasa, 2021).

Undeniably, such a stance has been further strengthened by political leaders who deliberately use Tuskegee rhetoric as a means of influencing Black Americans' choice on whether to get vaccinated or not (Jamison, 2020). They often presented data indicating that there was a relation between using vaccines and worsening health rates among the Blacks and that this knowledge was deliberately hidden from them. These arguments resonated quite well with political distrust of Black American citizens (Woko, Siegel, Hornik, 2020, pp. 819–820; Jamison, 2020).

Discussion: How does the 'Medical Apartheid' narrative relate to the vaccine hesitancy problem among the Blacks in the US?

In the previous chapter I presented the main features of vaccine hesitancy among Black Americans. As we could observe, they correspond with the concept of the 'Medical Apartheid' presented beforehand. Thus, we may argue that the idea, to some extent, can serve as a descriptive label for the analysis of health attitudes of the Blacks in the USA. Although the concept is emotionally engaging due to dark reminiscences of the political system in the South Africa, it grasps an important, intersubjective aspect of Black Americans' health status. Although it must be accentuated that not all Black citizens experience such problems regarding access to health care, the concept is still powerful and well resonates with American sensitivity to the Tuskegee and Lacks' cases. The 'Medical Apartheid' as a historical narrative combines cultural memories of racism, medical abuse and the neglect of actual health needs of many underserved Black Americans. Moreover, it puts together two important fields in modern societies where often trust is replaced by suspicion and fear, that is politics and medicine. On the one hand, 'Medical Apartheid' refers to political inequalities which are still present in America in a form of the so called 'structural racism' which further separates the Whites from other racial groups (Schmidt et al., 2020, pp. 2023–2024). On the other, the term refers to the idea of 'medical imperialism' which was quite popular in American society in the 60s regarding the lack of trust towards medical professionals who were blamed for medicalization of social problems. Both ideas assume that one side of a political or medical relation (politician-citizen and doctor-patient) did not act towards the other according to some norms in the past so there is no reason to trust them now. Since both concepts merge in one term it may be argued that the potential of the 'Medical Apartheid' narrative is even more powerful and resonates with feelings of isolation, disappointment and distrust experienced by many vaccine-hesitant Black Americans (Laurencin, Walker, 2020, pp. 9–10). Not only it describes their actual health situation, but also is a factor contributing to strengthening social bonds within the group whose members constantly feel deceived and oppressed. Also, as it has been stated elsewhere, the concept well fits in historical bad experiences of the Blacks regarding medical abuse illustrated by the Tuskegee Study and the lack of Henrietta Lacks' recognition in the discovery of the HeLa cells.

Still, it is necessary to highlight a few limitations to broader use of the idea. Firstly, the 'Medical Apartheid' concept is not a model in a methodological sense since it lacks proper operationalization. We must remember that the idea derives from non-scientific papers and in order to adapt it to rigorous political studies it is necessary to divide it into different categories which enable researchers to build measurable indicators. Only then it will be possible to empirically check the relevance of the idea to the real health situation of the Blacks. Until then the 'Medical Apartheid' is an idea which grasps some common resentments among Black communities in the USA and combine them with their difficult health situation resulting from many complex factors. The example of vaccine hesitancy among the Blacks seen from that perspective looks quite promising but needs to be further studied. Secondly, the concept was introduced in the 1990s which means that it rather refers to cultural memory of Apartheid or medical imperialism than to real historical experience. This is especially important if we would like to study the correspondence between emotional resentment which is present in the concept and current political distrust among the Blacks since the concept discussed in the article refers, above all, to the memory of the Apartheid and less to the Apartheid itself. Thirdly, using the idea as a theoretical frame without any further reservations may lead to wrong assumption that it describes the health position of all Black citizens in America which is not the case. It only describes some important features of the situation of those who are uninsured or insured by the state which means that economic, not racial, division may have the biggest impact. In this sense, one may ask about the position of the Whites who are in the same situation. On the one hand they are in a very similar situation as the Blacks, but on the other their ancestors were not experiencing Apartheid. Generally speaking, it seems clear that the concept refers only to the Blacks since the Apartheid policy was directly focused on them. Including White American citizens who may have experience similar distrust towards the anti-COVID vaccines would dissolve some basic integrity of the concept. Instead, it would be better to find other theoretical framework which grasps some main features of the general anti-vaccinal movement in America or gathers together common ideas expressed by those who are underprivileged in the American health system regardless of their racial identity. Fourthly, because of the fact that the concept has not been broadly discussed in the literature it is still too early to convincingly present its usefulness in political research. I argue that it may be used to describe two different phenomena: either the division between the Whites and the Blacks in American health care or intersubjective meaning of the idea for the Blacks. The latter research would focused on narratives and linguistical frames used by the Blacks who feel discriminated in public pillar of American health care system which fit in the scheme of the 'Medical Apartheid'. Finally, it is necessary to mention that successful lobby of American pharmaceutical industry also plays important role in public health awareness within the society (Snyder, 2020). This means that self-assuring approach regarding good health may not necessarily be a consequence of racial divisions but, rather, of medicalization and pharmaceuticalization of modern societies (Snyder, 2020; Pollock, Jones, 2015; Abraham, 2010).

Conclusions

The article aimed at defining the idea of the 'Medical Apartheid' which was popularized by Harriet Washington in her book on medical abuse of the Blacks in America. The idea which is based on cultural memories of medical experimentation on Black Americans including Henrietta Lacks refers to double standards in health care experienced by poor groups of Black Americans. Although the concept still needs to be operationalized it may serve as a good conceptualization of difficulties in the health care segment experienced by the Blacks in America. The usefulness of the concept was illustrated by the analysis of the main features of anti-vaccinal stance of Black Americans during the COVID-19 pandemic. The short analysis indicated that distrust towards national programme of vaccination may be partially explained by the strong presence of examples of medical abuse deeply rooted in their collective memory and is based on general political distrust towards the government which is still embedded in intersubjective conceptualizations of social reality. In this sense, the case of political distrust among the Blacks in America follows a similar scheme as the cells taken from Henrietta Lacks: it perpetually replicates from generation to generation even if its primary source, namely, the Apartheid officially disappeared many years ago. Unfortunately, this is not the kind of immortality that we would like to experience.

References

Abraham, J. (2010). “Pharmaceuticalization of Society in Context: Theoretical, Empirical and Health Dimensions”. *Sociology*, 44(4), pp. 603–622.

Ajasa A. (2021). “For some Black Americans, Vaccine Hesitancy Is Just One Part of a Legacy of Mistrust”. Available at *The Guardian* website: https://www.theguardian.com/society/2021/aug/20/black-americans-covid-19-vaccine-hesitancy-mistrust (accessed: 25.06.2022).

Alsan, M., Wanamaker, M. (2018). “Tuskegee and the Health of Black Men”. *The Quarterly Journal of Economics*, 133(1), pp. 407–455.

Bailey, Z.D., et al. (2017). “Structural Racism and Health Inequities in the USA: Evidence and Interventions”. *The Lancet*, 389(10077), pp. 1453–1463.

Batelaan, K. (2021). “«It’s Not the Science We Distrust; It’s the Scientists»: Reframing the Anti-Vaccination Movement Within Black Communities”. *Global Public Health*, pp. 1–14.

Bogart, L.M., et al. (2021). “What Contributes to COVID-19 Vaccine Hesitancy in Black Communities, and How Can It Be Addressed?”. Research Report of RAND available at: https://view.ckcest.cn/AllFiles/ZKBG/Pages/288/341536abb73df3df6ad0682d1c3ced3a0b416e9c.pdf (accessed: 27.06.2022).

BSI (2022). “HeLa cells (1951)”. Available at British Society for Immunology website: https://www.immunology.org/hela-cells-1951 (accessed: 27.06.2022).

Brooks, D.D., Smith, D.R., Anderson, R.J. (1991). “Medical Apartheid: An American Perspective”. *JAMA*, 266(19), pp. 2746–2749.

Callaghan, T., et al. (2021). “Correlates and Disparities of Intention to Vaccinate against COVID-19”. *Social Science & Medicine*, 272, pp. 1–5.

CDC (2022). “Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity”. Report of the Centres for Disease Control and Prevention available at: https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html (accessed: 27.06.2022).

Chandler, D. (2010). “The Underutilization of Health Services in the Black Community: An Examination of Causes and Effects”. *Journal of Black Studies*, 40(5), pp. 915–931.

Conrad, P. (2007). *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Baltimore: Johns Hopkins University Press.

Cortese, A.J. (2003). *Walls and Bridges: Social Justice and Public Policy*. Albany, NY: SUNY Press.

Dhawan, D., Bekalu, M., Pinnamaneni, R., McCloud, R., Viswanath, K. (2021). “COVID-19 News and Misinformation: Do They Matter for Public Health Prevention?”. *Journal of Health Communication*, 26(11), pp. 799–808.

Frazier, C. (2020). “It’s More Than Just News: Print Media, the Tuskegee Syphilis Study and Collective Memory among African Americans”. *Journal of Historical Sociology*, 33(3), pp. 280–296.

Dubé, E., Vivion, M., MacDonald, N.E. (2015). “Vaccine Hesitancy, Vaccine Refusal and the Anti-vaccine Movement: Influence, Impact and Implications”. *Expert Review of Vaccines*, 14(1), pp. 99–117.

Gill, M., Erevelles, N. (2017). "The Absent Presence of Elsie Lacks: Hauntings at the Intersection of Race, Class, Gender, and Disability". *African American Review*, 50(2), pp. 123–137.

Golub, M., et al. (2011). "A Community Mobilizes to End Medical Apartheid". *Progress in Community Health Partnerships: Research, Education, and Action*, 5(3), pp. 317–325.

Hamel L., Lopez L., Munana C., Artiga S., Brodie M. (2021). "Race, Health and COVID-19: The Views and Experiences of Black Americans". Available at Kaiser Family Foundation website: https://files.kff.org/attachment/Report-Race-Health-and-COVID-19-The-Views-and-Experiences-of-Black-Americans.pdf (accessed: 25.06.2022).

Hogan, M.J., Pardi, N. (2022). "mRNA Vaccines in the COVID-19 Pandemic and Beyond". *Annual Review of Medicine*, 73, pp. 17–39.

Kricorian, K., Turner, K. (2021). "COVID-19 Vaccine Acceptance and Beliefs among Black and Hispanic Americans". *PloS One*, 16(8), pp. 1–14.

Hoberman, J. (2016). "Why Bioethics Has a Race Problem". *Hastings Center Report*, 46(2), pp. 12–18.

Innis, J. (2022). "Medical Apartheid Author Harriet Washington Details History of Racism in Medicine". Available at UMass Chan Medical School website: https://www.umassmed.edu/news/news-archives/2022/02/medical-apartheid-author-harriet-washington-details-history-of-racism-in-medicine/ (accessed: 27.06.2022).

Jamison, A.M., Quinn, S.C., Freimuth, V.S. (2019). "«You Don't Trust a Government Vaccine»: Narratives of Institutional Trust and Influenza Vaccination among African American and White Adults". *Social Science & Medicine*, 221, pp. 87–94.

Jamison, P. (2020). "Anti-vaccination Leaders Fuel Black Mistrust of Medical Establishment as COVID-19 Kills People of Color". Available at *The Washington Post* website: https://www.washingtonpost.com/dc-md-va/2020/07/17/black-anti-vaccine-coronavirus-tuskegee-syphilis/ (accessed: 25.06.2022).

Johnson, K.A. (2017). "A Black Theological Response to Race-Based Medicine: Reconciliation in Minority Communities". *Journal of Religion and Health*, 56(3), pp. 1096–1110.

Laurencin, C.T., Walker, J.M. (2020). "A Pandemic on a Pandemic: Racism and COVID-19 in Blacks". *Cell Systems*, 11(1), pp. 9–10.

Laws, T. (2018). "Tuskegee as Sacred Rhetoric: Focal Point for the Emergent Field of African American Religion and Health". *Journal of Religion and Health*, 57(1), pp. 408–419.

Laurencin, C.T. (2021). "Addressing Justified Vaccine Hesitancy in the Black Community". *Journal of Racial and Ethnic Health Disparities*, 8(3), pp. 543–546.

Niño, M.D., Hearne, B.N., Cai, T. (2021). "Trajectories of COVID-19 Vaccine Intentions among US Adults: The Role of Race and Ethnicity". *SSM – Population Health*, 15, pp. 1–8.

Padamsee, T.J., et al. (2022). "Changes in COVID-19 Vaccine Hesitancy among Black and White Individuals in the US". *JAMA Network Open*, 5(1), pp. 1–12.

Peterson-Besse, J.J., et al. (2014). "Barriers to Health Care among People with Disabilities Who Are Members of Underserved Racial/Ethnic Groups: A Scoping Review of the Literature". *Medical Care*, 52(10), pp. S51–S63.

Pollock, A., Jones, D.S. (2015). "Coronary Artery Disease and the Contours of Pharmaceuticalization". *Social Science & Medicine*, 131, pp. 221–227.

Restrepo, N., Krouse, H.J. (2022). "COVID-19 Disparities and Vaccine Hesitancy in Black Americans: What Ethical Lessons Can Be Learned?". *Otolaryngology – Head and Neck Surgery*, 166(6), pp. 1147–1160.

Robillard, A.G., Annang, L., Buchanan, K.L. (2015). "Talking about Race: An Important First Step in Undergraduate Pedagogy Addressing African American Health Disparities". *Pedagogy in Health Promotion*, 1(1), pp. 18–23.

Rossmann, C. (1988). "Medical Apartheid in Canada". *CMAJ: Canadian Medical Association Journal*, 138(6), p. 492.

Schmidt, H., Gostin, L.O., Williams, M.A. (2020). "Is It Lawful and Ethical to Prioritize Racial Minorities for COVID-19 Vaccines?". *JAMA*, 324(20), pp. 2023–2024.

Skloot, R. (2010), *The Immortal Life of Henrietta Lacks*. New York: Crown Publishers.

Snyder, T. (2020), *Our Malady: Lessons in Liberty from a Hospital Diary*. New York: Crown Books.

Stump, J.L. (2014). "Henrietta Lacks and the HeLa Cell: Rights of Patients and Responsibilities of Medical Researchers". *The History Teacher*, 48(1), pp. 127–180.

Tai, D.B.G., Shah, A., Doubeni, C.A., Sia, I.G., Wieland, M.L. (2021). "The Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities in the United States". *Clinical Infectious Diseases*, 72(4), pp. 703–706.

Tikkanen, R.S., et al. (2017). "Hospital Payer and Racial/Ethnic Mix at Private Academic Medical Centers in Boston and New York City". *International Journal of Health Services*, 47(3), pp. 460–476.

Washington, H. (2008). *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. New York: Broadway Books.

WHO. (2022). "Noncommunicable Diseases". Available at World Health Organization's website: https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases (accessed: 25.06.2022).

Woko, C., Siegel, L., Hornik, R. (2020). "An Investigation of Low COVID-19 Vaccination Intentions among Black Americans: The Role of Behavioral Beliefs and Trust in COVID-19 Information Sources". *Journal of Health Communication*, 25(10), pp. 819–826.

Viswanath, K., Bekalu, M., Dhawan, D., Pinnamaneni, R., Lang, J., McLoud, R. (2021). "Individual and Social Determinants of COVID-19 Vaccine Uptake". *BMC Public Health*, 21(1), pp. 1–10.