

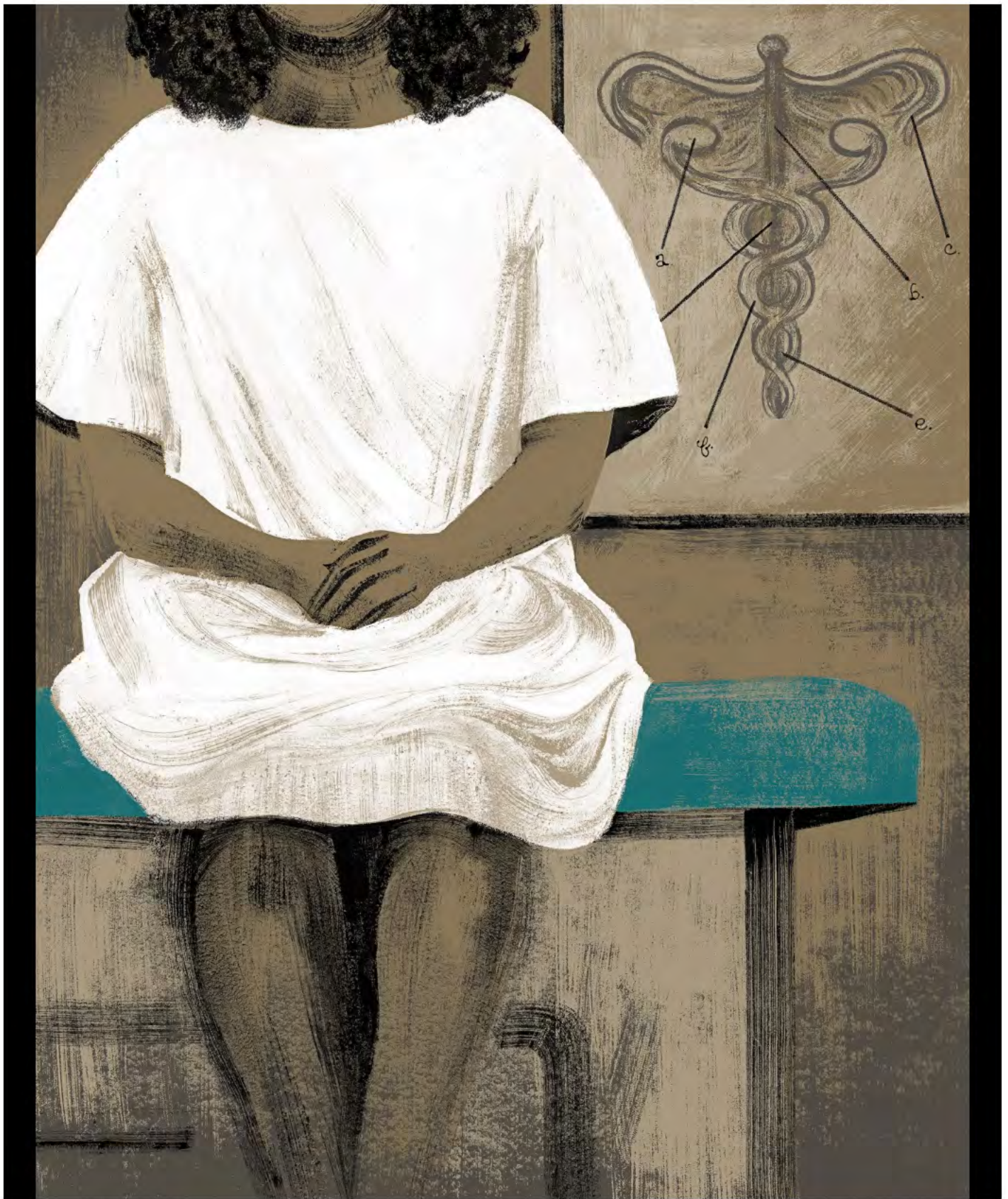
ANNALS OF MEDICINE

A PREVENTABLE CANCER IS ON THE RISE IN ALABAMA

*The state's refusal to expand Medicaid is causing poor women to miss out
on lifesaving screenings.*

By Eyal Press

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Cervical cancer disproportionately affects poor women and women of color. Illustration by Chloe Cushman



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One winter day in 2016, Tonya Carter felt a sharp pain in her lower back. In the months that followed, the pain grew more frequent and more diffuse, running down the back of her legs when she was sitting, and flaring up when she lay on the sofa in her living room at night. A devout Christian, Carter prayed that God, whom she referred to as “my ultimate physician,” would make the pain go away. It didn’t go away. She would have gone to see an actual doctor, she told me recently, but it was beyond her financial means.

Carter worked for Comfort Keepers, a company that provides in-home care for seniors. She liked the job, which involved tending to elderly people who required assistance with personal care and such chores as cooking and cleaning. Carter was a dedicated caretaker, sometimes fixing homemade corn bread and turnip greens for her clients. Her salary was low: eight dollars an hour, without benefits. “That’s good for around here,” said Carter, who lives in Anniston, a small city in northeastern Alabama with a troubled racial history—in 1961, a Freedom Riders bus was firebombed by a local mob—and an uncertain future. In 1999, a nearby U.S. Army base, Fort McClellan, closed down. Since then, Anniston’s population has shrunk, and the poverty rate has risen to nearly thirty per cent. Carter sometimes considered moving elsewhere, but her options were limited. At the time she started working at Comfort Keepers, she was divorced and had four children, three of whom still lived at home. Between rent, utilities, and providing for her family’s needs, her income was stretched far too thin to pay for health insurance.

In dozens of states, Carter would have qualified for Medicaid, particularly after the passage of the 2010 Affordable Care Act, which extended Medicaid benefits to all households earning up to a hundred and thirty-eight per cent of the poverty line. But in 2014, when Medicaid expansion took hold, Alabama and twenty-four other states, almost all of which had Republican-led legislatures, opted out; that year, Robert Bentley, then the state's governor, argued that it would burden taxpayers and foster "dependency on government." In Alabama, as in much of the South, the Affordable Care Act was derisively called Obamacare, and was attacked as a wasteful government program that showered benefits on undeserving recipients. In 2016, Donald Trump tweeted that Hillary Clinton "wants Obamacare for illegal immigrants." More recently, Jeff Sessions, who is running for his former Alabama Senate seat, aired a campaign ad accusing Democrats of plotting to provide "free health care for illegal immigrants." In fact, undocumented immigrants are ineligible for Medicaid, but it's not hard to imagine how such a claim might arouse indignation among poor voters in Alabama, where the income requirements for Medicaid are more stringent than in any state except Texas. In a family of four, a parent qualifies for benefits only if the household income is less than three hundred and ninety-three dollars a month—roughly eighteen per cent of the poverty line.

Carter had gone years without a routine checkup; she hadn't seen a gynecologist in more than a decade. As the months passed, her mind raced with theories about what might be wrong. Maybe she had kidney stones, or endometriosis. The pain spread through her abdomen and her pelvic area, and she began to bleed after intercourse. "It was just out of nowhere, and it was continuous," she said.

At work, Carter ducked into the bathroom whenever the pain grew unbearable, hoping that her absence wouldn't be noticed. After one such episode, she emerged to discover that her client, an elderly man, had walked outside and fallen. Although the man was not seriously injured, she was mortified by the incident.

By the summer, Carter was suffering so acutely that she finally sought medical care. The cause of her distress, she learned, was cervical cancer. Recently, a nurse informed her that the disease had advanced to Stage IV B: it had spread to her ovaries and other internal organs, and was considered terminal. Under Alabama law, now that she was sick, she qualified for Medicaid.

A century ago, cervical cancer was the deadliest form of cancer among women in the United States. Since then, the prevalence and the lethality of the disease have declined dramatically. The widespread use of Pap smears has allowed doctors to detect abnormalities earlier. And in 2006 the F.D.A. approved the use of the human papillomavirus, or H.P.V., vaccine, which can protect women from the most dangerous strains of the virus. Cervical cancer typically results from H.P.V. infections that are transmitted sexually.

Cervical cancer is now viewed by most physicians as preventable, and in more affluent parts of the country it is correspondingly rare. But in the poorer pockets of less wealthy states it remains disturbingly common. According to the American Cancer Society, more than four thousand women in this country will die from the disease this year. Women who develop cervical cancer in Alabama are more likely to die than their counterparts in any other state—and in recent years Alabama's mortality rate has been rising.

In 2018, Human Rights Watch published a report identifying some of the reasons for Alabama's outlier status. Sex education is not mandated in the public schools, which may help to explain why the state ranks low in H.P.V.-vaccination rates. In small towns and rural areas, the number of doctors and medical facilities has fallen, contributing to the proliferation of a disease that disproportionately affects poor women and women of color. The Human Rights Watch report found that Alabama women without medical insurance routinely delayed getting care, "which, for some, meant that gynecological cancers weren't found until symptoms developed to more advanced stages."

The Alabama Department of Public Health does operate a few programs that encourage prevention, including one that provides free screening for cervical cancer. But, because the program has a small budget and little funding for outreach, many poor women are unaware that it exists. Human Rights Watch found that only eighteen per cent of eligible women were using the program.

Tonya Carter, overwhelmed by pain, eventually visited a clinic in downtown Anniston which caters to low-income people. She was discharged without receiving any diagnostic tests. "They didn't even check my vitals," she told me. The doctor, who criticized her for not having a gynecologist, said, almost in passing, "Why haven't you contacted the health department?" She said nothing about free screenings. After visiting the clinic, Carter called her county health department, and learned of the state's screening program. By the time she got a test, the cancer had spread.

I met Carter on a damp, overcast morning in December, a few weeks after she received the diagnosis of Stage IV B cancer. She had invited me to accompany her to a CT scan at an outpatient clinic. She is forty-eight, with pale-blue eyes and a diffident manner. Her scalp was bare, from multiple rounds of chemotherapy, and her short-term memory was spotty—"chemo brain," she called it. The drugs had made her so fatigued that it was hard for her to get out of bed in the morning.

Nevertheless, Carter had forced herself to wake up early that day; like all her cancer-related medical appointments, the CT scan took place sixty miles west of Anniston, at a clinic near Birmingham. Since 2010, fourteen hospitals in the state, more than half of them in rural areas, have closed, forcing women to make long treks to get care. Corporate consolidation and low reimbursement rates from the federal government have contributed to the trend, but another major factor is Alabama's refusal to expand Medicaid. For years, the emergency rooms of rural hospitals have been inundated with poor, uninsured patients. Hospitals often receive no compensation for treating these patients, which lowers their operating margins and fuels what the Chartis Center for Rural Health has called a "closure crisis." In February, the organization reported that the eight states with the highest number of rural-hospital closures since 2010 had all declined to expand Medicaid.

Carter's fiancé, Patrick Poore, a soft-spoken man wearing rimless glasses and a Crimson Tide sweatshirt, had driven her to the appointment. Afterward, they invited me to lunch. They told me that they'd prayed together that morning, hoping for some good news. As Carter's condition worsened, she had to tell Comfort Keepers that she was too sick to work; as a result she lost her main source of income.

The one thing that she no longer had to pay for was medical care. The irony was not lost on her. "It took me having *cancer* to get some assistance," she said. "If I was going to yearly checkups, it could have been caught way before. If I'd had the means, the insurance, prior to that, then it would have been prevented."

Carter wondered how much longer she would be around to care for her children, including her youngest daughter, a seventeen-year-old who has diabetes. "There are days when I'm depressed," she said. "I worry about my children, and what their life would be like if I wasn't there." Tears pooled in her eyes. Carter then told me that she and Patrick, whom she began dating a few years ago, were in love, but that he was hesitant to marry someone who was terminally ill. "I want to know

what it's like to be married with him—to have a life with him,” she said, her voice thick with grief. “And I don't know if that's gonna happen.”

In Tuscaloosa, I met thirty-eight-year-old Laquisha Brant, who received a diagnosis of cervical cancer in 2019. She lives in a Section 8 apartment with a grime-stained entrance and bare walls. Before Brant learned that she had cancer, she was married and had a job at a nursing home. She was now too weak to work, her marriage had unravelled, and she was surviving on a combination of public subsidies and assistance from the Laura Crandall Brown Foundation—a nonprofit, based in Birmingham, that offers financial support to women with gynecologic cancer. “It's like my whole life had to stop,” she told me, over lunch at a Red Lobster. She listed other things she'd lost: her hair, her eyebrows, her vigor, her appetite. One bright spot was her doctor, who, she said, had helped her through the most difficult phases of her treatment. “She cried with me,” Brant said. But, though she was hopeful that her final chemotherapy treatment, in early December, would put her cancer in remission, she was unsure whether she could continue to get follow-up care, since a nurse had called her recently to inform her that her Medicaid was being cut off. Jennifer Young Pierce, a gynecologic oncologist in Mobile, told me that although low-income people with breast or cervical cancer qualify for Medicaid, the benefits were often discontinued once the disease went into remission. “It's ‘Good news, you're cancer-free!’—and then they drop you like a hot potato,” Pierce said. More than sixty per cent of cervical-cancer recurrences take place in the two years after an initial round of treatment has been completed. Any lapse in coverage could have dire consequences, Pierce said, since recurrences were “more often lethal than not.”

Pierce has been fighting for years to get Americans to change their approach to cervical cancer. A South Carolina native, she first witnessed the link between poverty and the disease while she was in medical school. As part of her residency, she worked in an outreach clinic in Cape Town, South Africa. The clinic's director,

Lynette Denny, had set up examination rooms in shipping containers, so that impoverished women living in remote townships could be screened for cervical cancer; in developing countries, the disease remains one of the leading causes of women's death. Denny urged Pierce to provide similar services for vulnerable women in her own community. In 2012, Pierce and a colleague launched an organization called Cervical Cancer-Free South Carolina, and also helped run a mobile-clinic outreach unit that dispatched an R.V. to rural areas to offer Pap smears.

A few years ago, a friend recruited Pierce to come to Alabama, where the cervical-cancer problem was even worse. She now runs the Cancer Control and Prevention program at the Mitchell Cancer Institute, in Mobile. One of her missions, she told me, was to educate other doctors in the state about the H.P.V. vaccine, which many pediatricians in Alabama recommend halfheartedly, perhaps accepting the unfounded view that it encourages sexual activity. Pierce told me that she's been going "door to door," trying to persuade pediatricians to push back when families resist vaccinating. It was difficult work, she said, not least because two dozen counties in Alabama had no pediatricians, which meant that she had to "track down family-medicine doctors," who are less likely to offer vaccinations in the first place. She also had to treat the gravely ill women who flowed into her clinic "like the tide." On Christmas Eve, she'd attended to a young woman in her mid-twenties as she died of cervical cancer. Pierce informed the woman's parents and siblings, who rushed to the intensive-care unit to say goodbye. Everyone in the room was sobbing, Pierce recalled. Even when cervical cancer was caught at an early stage, she said, the standard treatment was "a horror"—weeks of intensive radiation that caused aneurysms, sexual dysfunction, infertility, and scarring. "There are days when I feel like we are on the front lines of an epidemic that nobody wants to talk about," she told me.

Along with increasing vaccination rates, broadening access to health care is an obvious way to fix the problem. But, in much of the South, a surprising number of

the poor and working-class people who would benefit from changing the system are opposed to doing so. A few years ago, Jonathan Metzl, a psychiatrist and sociologist at Vanderbilt, began organizing focus-group discussions near churches and low-income housing projects in Tennessee, which, like Alabama, had refused to expand Medicaid under the Affordable Care Act. At one such meeting, in Nashville, a group of working-class white men were invited to talk about the health-care system. Many of the participants—amputees, men with oxygen cannisters—were in visibly poor health. Some acknowledged having to rely on various forms of assistance to deal with their ailments. “I would be dead without Medicaid or the V.A.,” one man said. But, when Metzl asked about the role of “government” and about programs such as the Affordable Care Act, a man complained that people on welfare with “ten and twelve kids” were abusing the system. Another claimed that “illegal mothertruckers” received all the benefits, and that ordinary Americans were subsidizing them. A flurry of complaints about Mexican immigrants followed, prompting one man to say, “We’re starting to sound like Donald Trump.”

In 2019, Metzl published a book, “Dying of Whiteness,” in which he argued that people who voiced such views, fuelled by racial animosity and “the toxic effects of dogma,” ended up supporting policies that put their own lives at risk. “No way I want my tax dollars paying for Mexicans or welfare queens,” a white former cabdriver suffering from terminal liver disease told him. “Ain’t no way I would ever support Obamacare, or sign up for it. I would rather die.” A growing body of evidence suggests that clinging to such beliefs has indeed shortened lives. States that expanded Medicaid under the Affordable Care Act have seen reductions in mortality from kidney failure and cardiovascular disease, along with an increase in early-stage cancer diagnoses. They have also seen lower rates of infant and maternal mortality. A study published last July by the National Bureau of Economic Research estimated that, from 2014 through 2017, states that expanded Medicaid saved the lives of more than nineteen thousand adults between the ages

of fifty-five and sixty-four alone. In the states that rejected expansion, the researchers concluded, fifteen and a half thousand lives were lost.

The data, though striking, may not be enough to loosen the hold of racial resentment. As Metzl and others have pointed out, states where benefits are scarce are precisely where this kind of anger is most likely to flourish. Since the early two-thousands, the journalist Thomas Frank and other writers have argued that Republicans, by harnessing such frustrations, have repeatedly persuaded many working-class citizens to vote against their economic interests. Metzl contends that Republicans have been just as adept at getting lower-income whites to vote against their “biological self-interests.”

Tonya Carter, of Anniston, told me that she didn’t follow politics closely—her fate, she liked to say, was in God’s hands. But, in our initial phone conversation, she said that if she had been able to get insurance through the Affordable Care Act she surely would not have developed advanced cancer. This made me think that, unlike the working-class men quoted in Metzl’s study, she believed that the government has a responsibility to care for people who cannot afford to pay for health insurance. When Carter and I met, she told me how optimistic she’d been when she first heard about the A.C.A. “I was so excited,” she said. “I was hoping that it would benefit me.” Then she went online and learned that the cheapest plan cost hundreds of dollars a month—far more than she could afford. Her enthusiasm gave way to bitterness. “What came out of Obama’s mouth?” she said. “ ‘Every citizen will have insurance.’ And it failed. To *me*, it failed, and I’m pretty sure there are other people in my shoes who feel like it failed.”

But Carter did not fully comprehend why the Affordable Care Act had “failed” in Alabama. She didn’t realize that, in the three dozen states that have expanded Medicaid since 2014, the law had made it possible for millions of low-income people to get insurance at no cost. When I mentioned this, she looked surprised and distraught. “It’s pretty upsetting to hear,” she said. She was even more perturbed to hear that a common reason cited by politicians for rejecting Medicaid expansion was a desire to avoid burdening taxpayers. “I wonder what those people who don’t want their taxes to be raised—what if they had a loved one in my shoes?” she said. “What’s the cost of giving the citizens of Alabama insurance versus allowing us to die?”

According to a study conducted by David Becker, an economist at the University of Alabama at Birmingham, expanding Medicaid would by now have cost Alabama seven hundred and seventy-one million dollars—a figure that reflects both treatment costs and administrative expenses. But Becker calculated that, even with the federal matching rate for new Medicaid enrollees starting to fall in 2017, these costs would be more than offset by folding existing state programs into Medicaid, and also by levying taxes on the billions of Medicaid dollars spent in Alabama. Indeed, he believed that expanding Medicaid would generate a net *surplus* of nine hundred and thirty-five million dollars. Becker told me recently that he had expected his study to inspire “some debate” in the Alabama legislature. “That never happened,” he said. Perhaps this was because many of the voters in Alabama who stood to benefit most from Medicaid expansion kept backing

politicians who opposed it. As I discovered, Tonya Carter was one of those voters. Although she didn't consider herself to be a political person, she told me that in the 2016 Presidential election she voted for Donald Trump, who is intent on overturning the Affordable Care Act.

"I had my reasons," Carter said of her vote. Trump is a businessman who, she figured, could "help the economy, maybe make a difference." I asked her if this had happened in Anniston. "Not yet," she replied.

She then mentioned another reason that she supported Trump. It really bothered her that "foreigners" could come to America and "get free health care, free assistance in living, food stamps," while many U.S. citizens were denied these things. "It's not right when you are born here, and you pay taxes, and you work your tail off your whole entire life, and you still can't get health insurance," she said. "But a foreigner can cross the border and they *instantly* get their needs met." She paused. "That's one reason why I voted for Trump. I don't think it's right."

Jim Carnes, a health-policy expert at Alabama Arise, an antipoverty organization, told me that expanding Medicaid would provide coverage for roughly three hundred and forty thousand additional Alabamians. About half of the newly insured would be low-income whites. Carnes doubted that this was common knowledge among white Alabamians, given the deeply ingrained popular association of public benefits with poor African-Americans and Latino immigrants. Robyn Hyden, the executive director of Alabama Arise, told me that early in her career, when she was an organizer in northern Alabama, she tried to educate low-income people about health care and the Affordable Care Act. "When you actually talk to people about the policy, it's very popular" among both liberals and conservatives, she said. "But, in general, people don't come into the room knowing about it. They've heard a partisan message about it."

Broadening access to health care in such states as Tennessee and Alabama would not, of course, benefit whites alone. A few days before meeting Tonya

Carter, I drove to the Vaughan Regional Medical Center, in Selma, in the heart of Alabama's Black Belt. Named originally for its rich, dark topsoil, the Black Belt was once dotted with cotton fields and slave plantations. During the civil-rights movement, it was a center of political ferment. More recently, the region has become known for the staggering poverty among its majority-African-American residents. In 2017, Philip Alston, the U.N.'s Special Rapporteur on extreme poverty and human rights, visited the Black Belt, and saw raw sewage being dumped outside homes in rural areas; he told a local reporter that he had never seen such deprivation in the First World.

The rural counties in the Black Belt were the focus of the Human Rights Watch report on cervical cancer. As the report noted, black women in Alabama are almost twice as likely as white women to die if they develop the disease.

Experts attribute this to racial discrimination that is embedded in the health-care system and to the likelihood that, when African-Americans do receive care, it is often of lower quality. The Human Rights Watch report notes that, "even when Black women with cervical cancer earn as much as white women, they are still at higher risk of death from the disease."

Among the physicians quoted in the report was William Michael Stevens, an ob-gyn who runs the women's-health clinic at the Vaughan Regional Medical Center. In the report, Stevens described the case of a woman in her twenties who had come to see him because she was bleeding after intercourse. She had gone to the emergency room three times, but had not received a pelvic exam on any of the visits. She hadn't undergone a Pap smear in years. When he performed an exam, he discovered that she had advanced cervical cancer.

"There's been several cases like that," Stevens said when I visited him, in his cluttered office, on the fourth floor of the hospital. In his view, the medical system was not always to blame. Sometimes patients who had gone to screenings and had

abnormal Paps didn't return for follow-up procedures. "Compliance is a big problem," he said. But Stevens, who grew up poor, added that he understood why women in the Black Belt sometimes failed to make it to appointments. Getting a colposcopy cost several hundred dollars, which patients without coverage often couldn't afford, and many patients had to drive long distances to reach his office. He opened a red folder on his desk and pulled out a pamphlet comparing Alabama's rural counties in 1980 and in 2019. In the 1980 map, forty-five of the fifty-four rural counties had hospitals that provided obstetric services. In the 2019 map, just sixteen did. This, too, was a product of Alabama's refusal to expand Medicaid, which led rural hospitals to cut essential services in order to avoid going out of business. Stevens pointed to several counties surrounding Selma: Wilcox, Chilton, Lowndes. "None of these counties have any ob-gyn coverage," he said.

Dallas County, where Selma is situated, once had three hospitals. Today, the Vaughan Regional Medical Center is the only one that remains open. When Stevens first joined its staff, he was one of seven ob-gyns. He now had just one colleague, Shawnequa Brown, who first visited Selma to attend a nephew's high-school graduation. In 2018, she came back to serve as a medical provider, because, she told me, "there's such a need." One factor driving the need was episodic health-care coverage. Many women in the area would see a doctor while pregnant, because they qualified for Medicaid, but stop going when coverage was withdrawn. "Once they're no longer having children, they just don't get checked," Brown said. Another problem was a lack of education, which sometimes led women to think that they'd been given cancer screenings even though they hadn't. "I'll ask a patient, 'When was your last Pap smear?'" Brown said. The patient would say, "Oh, I had one at the emergency room." Then Brown would check and discover that the procedure was actually a speculum exam, which does not screen for cancer.

Isabel Scarinci, a behavioral psychologist at the University of Alabama's Division of Preventive Medicine, said that, among poor women, a lack of education was

sometimes compounded by a sense of resignation. “Women may think, If I find out I have cancer, how can I deal with it?” she said. Scarinci is one of the leaders of the Deep South Network for Cancer Control, which trains local volunteers who work to reduce rates of disease in low-income minority communities.

Shortly after visiting the hospital in Selma, I drove thirty miles northwest to Marion, a small town in Perry County, to visit a nonprofit called Sowing Seeds of Hope, which works with Deep South Network volunteers. Housed at the end of a rutted dirt path, it operated everything from a weekly hypertension clinic to a child-screening program for vision problems. Its executive director, a nurse named Frances Ford, described these services as “Band-Aids” in a county where more than one in three people were poor. We walked to a low-slung building on the other side of the dirt path: the Perry County Health Department. While there, we spoke with Pilar Murphy, a pharmacist, who catalogued the obstacles patients faced. “Some of it is transportation, some of it is funds,” she said. “Some of it is just knowing how to traverse through the health-care system.”

I asked Murphy how much of a difference it would make if Alabama expanded Medicaid. “It would be huge,” she said. She described the case of a sixty-two-year-old man with a history of cancer and diabetes who had recently lost his medical insurance. Murphy had helped him find low-cost options for his diabetes medication, but the man still had to pay out of pocket for follow-up care, and was consequently avoiding doctor visits.

After we chatted with Murphy, Ford took me on a tour of Perry County and drove past some of the rudimentary local housing—trailers coated in rust, shacks missing doors and windows. We pulled up to an attractive red brick building set behind a metal fence and a line of trees: the former local hospital. Ford had been advocating for Perry County to open a new one—she understood how difficult it could be for poorer residents to drive several hours to see a specialist. After her own mother learned that she had cervical cancer, in 1980, she had been forced to drive all the way to Birmingham for care. In the car, Ford reached into her coat

pocket and handed me a letter that her mother had written. Addressed to her children, it described her waning energy and a mounting sense that there might not be “many more tomorrows.” A few weeks later, Ford told me, her mother died.

One day, I met a woman named Lacie Gunter, a single mother with two young daughters who lives in a housing complex in West Mobile. A few years ago, she began feeling pain in her side. When the pain grew excruciating, she started showing up at the nearest emergency room, hoping to see a doctor. She’d been on Medicaid when she gave birth to her younger daughter, five years ago, but when she presented her Medicaid card she was informed that her coverage had lapsed. She told me that, at these E.R. visits, she was never given a Pap smear or encouraged to get a cancer screening. (None of the women with cervical cancer I interviewed in Alabama had been aware of the free screenings.) Gunter did receive plenty of judgmental looks, from nurses who saw her address, and her bad teeth, and assumed that she was an alcoholic or a dope addict. In fact, she does not drink or do drugs. “I’d say, ‘I’ve never done drugs in my life—please help me,’ ” she said. “They did not believe me.”

Gunter eventually stopped seeking care. Early one morning, at around two-thirty, she woke up in writhing pain. When she went to the bathroom, she saw that she was bleeding. After taking her older daughter to school, she set off for her mother’s house to drop off her younger daughter, thinking that she could then

head to the hospital. But on the way to her mother's house she began feeling light-headed. She pulled into a Dollar Store, where she bought some Tylenol and went into the bathroom to try to stanch the bleeding, which had got heavier. From the parking lot, she called her parents and told them that she needed help. Her father picked her up and drove her to the emergency room. Gunter told the nurses, "I'm dying—I'm bleeding out." After twelve hours of waiting and a series of examinations, she was transferred by ambulance to Children and Women's Hospital, where a gynecologic oncologist performed a biopsy, under anesthesia, and initiated instant radiation. Later, Gunter learned that she had advanced cervical cancer.

By the time I met Gunter, in November of last year, she had undergone months of chemotherapy and radiation treatment. She was hopeful that the cancer would go into remission, but she knew that, if it did, she could once again be without insurance. "I'm terrified," she told me.

Her physician was Jennifer Pierce, the gynecologic oncologist, who was on call at Children and Women's Hospital on the day that Gunter was brought in. Pierce said that Gunter had been lucky. "A patient who is hemorrhaging from cervical cancer without appropriate medical care absolutely could die—quickly," she told me. Pierce explained why Gunter's illness should never have advanced so far. One missed opportunity came in 2010, when Gunter, at the age of twenty-one, gave birth to her first daughter: she could have been administered the H.P.V. vaccine during that hospital visit. Then there was the period after Gunter's Medicaid lapsed, when she stopped getting checkups or seeing a doctor.

Gunter is thirty-one, with dark- brown hair and a weary gaze. Like Tonya Carter, she told me that she is not a political person, but she grew angry when recalling how she felt during her visits to the E.R. "Had they just given me *one chance* to explain the type of pain I was in, had someone just done one simple exam, they would have found it," she fumed. "I was not treated like I was even a person, really." Gunter told me that she still woke up every morning to braid her

daughters' hair, but she worried that her physical limitations might cause them to suffer. Before getting cancer, she'd hoped to be trained as a welder; now she wasn't healthy enough to begin searching for a job. "I wake up and I'm in pain, I go to sleep and I'm in pain," she said. "I'm stuck—I've got girls to take care of, and I don't have very much help." A proud Alabamian who told me that there was no other place she wanted to live, she expressed frustration about another thing: when people in Alabama talked about protecting "life," it always seemed to be about unborn babies, and never about poor women like her. "That bothers me to my core," she said.

To Gunter, this smacked of hypocrisy. But it was also possible to see Alabama's strict anti-abortion laws as consistent with the state's general lack of concern for the health and well-being of poor women. "In Alabama, we have one of the highest maternal-mortality rates in the country," Jennifer Pierce told me. "It is more lethal to be black and pregnant in Alabama than in some poor countries."

Pierce and other activists have had some success in their fight against cervical cancer. Since 2010, the proportion of adolescents in Alabama receiving a dose of the H.P.V. vaccine has increased from forty-six to sixty-five per cent, and there are signs that opposition to the Affordable Care Act has begun to soften. "It's a function of distance from the Obama Administration," Jim Carnes, of Alabama Arise, told me. It was also a function of Alabama officials seeing health indicators in other states improve while their own population suffered and rural hospitals slid further into crisis. Cervical cancer was just one aspect of the problem: a vascular surgeon in Montgomery described to me a similar pattern with heart disease. People sought medical attention only during a heart attack, or after developing extensive vascular disease. Such delays put lives at risk and, the surgeon pointed out, also drove up the cost of care.

In the past few years, a number of conservative states that had initially opposed the Affordable Care Act, including Virginia and Louisiana, have reversed course and expanded Medicaid. Edward Partridge, a gynecologic oncologist and a former

director of the University of Alabama's Comprehensive Cancer Center, believes that this will soon happen in Alabama. When I asked him why, Partridge, who is a Republican, said, "It's insanity—how long can insanity last?" J. David McCormack, the C.E.O. of the Vaughan Regional Medical Center, the last remaining hospital in Selma, told me, "I'm a conservative person. But we've got to do Medicaid expansion." The spread of COVID-19 further imperils the state's health-care system. On March 24th, David Becker, the economist, published an op-ed in the *Birmingham News* arguing that, given the threat posed by the pandemic, "now is the time to finish Medicaid expansion in Alabama."

One person who has yet to come around to this position, at least publicly, is Kay Ivey, Alabama's Republican governor. Ivey, who has the authority to sign a rule change that would expand the program, declined to comment for this article. But she is surely aware that many people in her state lack health care. Ivey grew up in Wilcox, a county in the Black Belt which, a few years ago, had to scramble to prevent its only hospital from closing. Last year, she was among the elected officials who received a copy of a report issued by the Alabama Study Commission for Gynecologic Cancers, a coalition of medical specialists, administrators, and survivors appointed by the Alabama legislature and the state's governor. The report contained some startling passages. "Cervical cancer is almost entirely preventable and yet in Alabama there are areas where women are dying at a rate similar to that of developing nations," it noted. It also pointed out that Alabama has the third-highest ovarian-cancer mortality rate in the country, even though cases of ovarian cancer are slightly less common in the state than in the U.S. as a whole.

These findings may not move Ivey, who, in 2018, proposed establishing a work requirement for the small portion of parents and caregivers in Alabama who receive Medicaid, forcing poor people who must care for a child or a disabled adult to find jobs or lose their benefits. (The proposal remains before the state legislature.) But Ivey, who is seventy-five, has since had some health problems that

may have deepened her appreciation of how essential access to medical care can be. Last August, during a routine medical exam—the kind of checkup that women without insurance usually go without—a doctor discovered a small malignancy in her lung. Fortunately for her, the cancer was detected early, and treated immediately, with stereotactic body radiation therapy, at a state-of-the-art oncology center in Montgomery. In January, scans revealed that Ivey was cancer-free. “I am profoundly grateful for this good news,” she announced, thanking God, her “dedicated team of physicians,” and “the good people of our great state.” ♦

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