

Segregation in Health Care

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FROM THE EDITOR

A Call for Health Care Desegregation

Denisse Rojas Marquez, MD, MPP and Hazel Lever, MD, MPH

Structural racism within health care has become a recent priority for many academic health centers (AHCs) nationally. In this theme issue, we suggest that one important way to prioritize this topic is by assessing ways in which de facto racial segregation continues in health care today. Segregation has not received much attention, but practices of sorting patients into different tracks of care within a facility or system by insurance status,¹ race,² and other social demarcations exist, which is what we shall call *segregated care* in this theme issue. While sanctioned racial segregation in hospitals ended with the Civil Rights Act of 1964 and subsequent implementation of Medicare in 1966,³ health care organizations continue to practice de facto racial segregation today. Beyond individual institutions, segregated care exists at the **city level** through unequal resource distribution and health insurance inequity.^{4,5}

As students in an AHC, we witnessed segregation of our patients daily. Patients with Medicaid are triaged to resident and fellow clinics—staffed by trainees—while privately insured patients largely receive care in another building and are seen by faculty, attending physicians who have completed their training and certifications. It is important to acknowledge that **segregation based on insurance** is a de facto proxy for segregation by race far too often. In New York State, 18% of nonelderly Medicaid recipients are White, whereas an estimated 62% of nonelderly patients with employer-provided coverage are White.^{6,7} One study found that resident physicians in an AHC saw disproportionately more Black and Latinx patients than did attending physicians, as well as disproportionately more patients on Medicaid.⁸ When physicians-in-training see disproportionate numbers of patients of color compared to fully trained and licensed physicians, undoubtedly there are differences in quality of care that patients receive. In our conversations with other students and health justice advocates, we came to learn that this practice is common at AHCs, both in New York City and throughout the United States.

Two recent studies have pointed to the potentially large impact of segregated care on health outcomes in communities of color. In a 2019 study of primary care settings, patients treated by residents were less likely than patients treated by attending physicians to reach chronic disease management and cancer screening benchmarks.⁸ Another study found that Black and Latinx patients who presented to one large urban AHC's emergency room with heart failure exacerbations were less likely than White patients to be admitted to the cardiology service, which is known to have better health outcomes for patients admitted with heart failure than the general medicine service.⁹

Segregated health is reminiscent of a “separate but equal” doctrine that upheld *de jure* racial segregation through Jim Crow laws up to the mid-1900s.^{10,11}

In our time navigating medical school and subsequently, residency, we came to see the ramifications of this practice on us as trainees. We began our studies with ideals based on our school’s mission to champion exceptional patient care for all patients; yet we came to see that patients with low incomes face significant impediments to their care in a 2-tiered system. We were indoctrinated into this system of care as the status quo and witnessed the ways in which our superiors acted within it: they taught us the practice of medicine without mentioning underlying patterns of racism in our segregated practice and, when acknowledging the existence of segregated care, they showed no agency by acting to change it. To say the least, we had neither a name for the phenomenon of segregated care nor a common language with which to discuss it in our health care communities.

As students, we **engaged in advocacy** in an attempt to start conversations about segregated care and to move the needle toward integration. Our conversations with clinical leadership were eye-opening—reactions ranged from denials of racial segregation (“It’s not race, it’s class!” said one clinical leader), to outright defenses of classism (“If you have more money, you stay at a nicer hotel!” said one department chair), to actively working toward integration. We struggled with how to get such leaders to take ownership of and accountability for their troubling views that illuminate need for change in deeply entrenched patterns of unjust support of a status quo. Several hospital administrators simultaneously denied the existence of segregated care and insisted that the problem was being fixed, then wished us luck with “our project” on the way out the door. In the face of such resistance, we turned to the academic literature for help in supporting our cause and situating modern segregated care within its historical, legal, and economic context, only to find published work on the topic sparse.

We aim in this issue to open an academic dialogue on segregated care, one that can be drawn on by health justice advocates to begin to dismantle segregated systems. This issue incorporates multidisciplinary perspectives and questions on segregated care and desegregation, including the history of segregation in health care; why legal arguments have failed to desegregate health care; how financial systems can be used to advance health equity; how health care for “very important persons” reifies segregation; the influences on students and trainees of learning within a segregated system; the roles that AHCs can play in desegregating their departments and organizations; and the responsibilities of AHCs to communities they serve.

In having this dialogue in an academic journal, we recognize that the most important participant in this conversation is missing: the actual communities whose health and well-being is affected by our segregated systems of care. Academic health care tends to value publication as the final endpoint of research and as the only valid type of knowledge; however, working toward desegregation requires more than what can be encompassed in a journal. It involves recognizing, supporting, and elevating community members’ voices and, at times, putting one’s own welfare, career, or reputation at risk in doing so.

There is no one answer to how to promote desegregation. Segregated systems are deeply entrenched in how we learn medicine and deliver care and in how profit incentives tend to exacerbate inequity. The act of dismantling racism in health care

requires all health care staff to recognize their own complicity in a racist health system—despite the fact that they did not create it. We hope that the articles in this issue will start a conversation, spark inspiration for change, and lead to concrete action nationally to desegregate health care. Segregated care is a problem each of us in health care must own, and we all have a responsibility to create a more just system.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

**How Should Health Professions Educators and Organizations
Desegregate Teaching and Learning Environments?**

Aisha James, MD, MEd and Katrina A. Armstrong, MD, MSCE

Abstract

Motivating health equity requires taking deliberate steps toward desegregating health care, especially in academic health centers. One step should incorporate rigorous measurement and assessment of patients' access to health services and ongoing collection and review of patients' health outcomes data. Another step should develop, fund, incorporate and administer initiatives with community members that address social determinants of community and individual health, including academic health centers' inpatient and outpatient service delivery sites, insurance programs, and federal policy. Academic health centers must also be accountable for monitoring initiatives' successes and failures over short- and long-term trajectories and for modifying initiatives' methods as needed to achieve equity in access to health services and health outcomes.

Case

Dr W is a well-respected, well-liked physician of some status in the Department of Medicine at University Health (UH), an academic health center in the middle of a campaign to recoup "charity care" losses incurred when patients with insufficient insurance or no insurance can't pay or when care of Medicaid patients is reimbursed at a low rate. The campaign continues with the UH network opening SwankCare, which will be staffed exclusively by UH faculty subspecialists. Patients eligible to receive SwankCare inpatient, outpatient, or expedited laboratory services must be sufficiently resourced to pay out of pocket, as neither Medicare nor patients' insurance of any kind will be accepted.

Even now, resident physicians and fellows typically see patients insured by Medicaid or Medicare in UH outpatient clinics, while patients with generous insurance coverage and Medicare supplemental insurance are funneled into attending faculty practices. This trend is a source of ongoing concern among a growing number of community activists, as well as students, trainees, and faculty in medicine, nursing, pharmacy, and physical therapy programs, who have voiced concern about these practices' roots in race- and class-based patterns of oppression in US health care and about their perpetuation and growth in UH network campaigns like SwankCare.

Dr W hopes to join colleagues speaking out to promote health equity but isn't sure how to be part of the solution. Specifically, Dr W wonders how UH services should be delivered to promote revenue sharing that would enable more efficient, network-wide coordination of care and service integration and wonders how to gain needed support from colleagues of status who don't share the view of equity as a goal of health care.

Commentary

Much like other major institutions within the United States, health care was built on a foundation of segregation.¹ While legal segregation of hospitals officially ended in 1965,² health care's racist and classist roots—manifest in individual bias and systemic inequities—perpetuate segregated care today. Race-neutral or color-blind policies and practice have proven to be ineffective in overcoming this history.³ In order to achieve desegregated care and ultimately health equity, the US health care system, as well as health care institutions and leaders, must take deliberate action to dismantle segregation at all levels. In what follows, we will focus on how individual institutions—and, in particular, academic health centers—can take steps to end segregation.

Measuring and Characterizing Segregation

Segregation of racial and ethnic groups within health care (eg, by insurance type, facility, clinician, and treatment) is well established, although it varies by institution.^{4,5,6,7,8,9,10,11} We cannot fix a problem that we don't measure and monitor. Thus, the first step to successfully desegregating health care is the implementation of **large-scale and regular data analysis** of different levels of segregated care. Many institutions collect some relevant data,^{12,13} but the data are not consistently analyzed, acted upon, or made available to the public. Patients of different racial and ethnic backgrounds may be cared for at different institutions within the same city or region, for example. Consider Boston, Massachusetts, with a population that, in 2021, identified as 9.8% Asian, 24.2% Black, 19.5% Hispanic/Latino, and 52.1% White.¹⁴ Despite the small physical size of the city and accessible public transportation, there is substantial racial residential segregation that contributes to substantial racial segregation across medical institutions, with the majority of Black and Hispanic patients being cared for at Boston Medical Center (BMC) rather than Massachusetts General Hospital (MGH), which is roughly 3 miles away from BMC by car.¹⁵ While both institutions are well respected academic medical centers known for quality care, only MGH has consistently been ranked among the nation's top hospitals.¹⁵ Similar patterns of segregation are seen in cities across the country; however, unlike in Boston, most patients of color are clustered at underperforming hospitals.^{10,15}

Within a single institution, patients may be cared for at different clinics or on different inpatient units. Black and Hispanic patients hospitalized for congestive heart failure are more likely to be cared for on a general medicine-surgical unit than White patients, who are more likely to be admitted to the cardiology service.¹⁶ In the outpatient setting, many institutions have separate clinics for medical trainees, who often care for patients with limited or public insurance.^{17,18} In the United States, such patients are far more likely to be from racial and ethnic groups that have been historically marginalized.¹⁹

Even within the same clinic or unit, patients of different racial and ethnic backgrounds may be cared for by different types of clinicians. In the hospital, Black and Hispanic patients with congestive heart failure are less likely to receive specialty consultation than White patients, despite evidence of improved outcomes with specialty care.²⁰ Moreover, several studies show that trainees care for more Black and Hispanic patients

than do faculty physicians within the same practices.^{21, 22} There is also evidence that racial and ethnic minority patients are more likely to be cared for by physicians who identify as younger in age, not board certified, having less clinical experience, and having fewer resources.^{23, 24, 25}

Lastly, segregated care goes all the way down to the treatment level. Patients cared for by the same clinicians in the same clinic or unit at times receive diverging treatments that fall along racial lines. Even after controlling for sociodemographic and clinical characteristics, Black, Hispanic, and Indigenous patients with atrial fibrillation are less likely to be treated with direct oral anticoagulation therapy (DOAC) than White patients, despite evidence of DOAC's superior clinical outcomes and safety compared to warfarin.²⁶ Whether it be first-line treatment for atrial fibrillation or cellulitis, genetic counseling for hereditary breast cancer risk, or supportive care after a cancer diagnosis, many studies show that American Indian/Alaska Native, Asian, Black, Hispanic, and Native Hawaiian/Pacific Islander patients are less likely to receive standard-of-care treatment than White patients.^{23,26,27,28}

Each institution's segregation pattern(s) will differ, and thus a full understanding of the type and severity of segregation taking place is needed to remedy the problem. Institutions will require a system to collect, maintain, and analyze patient access and outcomes data stratified by race, ethnicity, and other key demographic factors.¹²

Root Cause(s)

The etiology of health care segregation is multifactorial. While it is clear that residential racial segregation contributes to health care segregation,¹⁵ there are many factors that drive health care segregation that are well within the control of individual health care institutions.^{4,5,6,7,8,9,10,11,29} These include which types of insurance are accepted and prioritized, referral networks, location of facilities, available support services, staff diversity, and instances of discrimination and other behaviors that perpetuate distrust.

Given the correlation between race and ethnicity and insurance type in the United States, with White people being more likely than people of color to have private insurance,³⁰ decisions about which insurance plans to accept can have a major impact on health care segregation.¹⁹ Clinicians and provider organizations that do not accept Medicaid plans because of the relatively lower level of reimbursement will see fewer patients of color, thereby concentrating patients of color among those clinicians and provider organizations that do accept those plans. This pattern of insurance discrimination in turn leads to patients of color being cared for at institutions with less funding and fewer resources, which compromises the care they receive.^{24,25} Many health care systems concentrate on developing **referral networks** that bring patients with private insurance to their clinics and hospitals to maximize reimbursement. By placing satellite sites in communities with higher rates of private insurance, these systems make it less likely that patients of color will be referred to their facilities. Access to care is further reduced by health care systems' failure to accommodate patients' scheduling, linguistic, transportation, and other social needs. For many historically marginalized racial and ethnic groups, the availability of evening and weekend clinic hours, on-site interpreter services, facilities accessible by public transportation, and flexible no-show policies is critical for enabling access to care.^{31,32,33,34,35,36} Such constraints can result in fewer patients seeking care at a given institution, a reality that can be misinterpreted as patient preference.³⁷

Race-neutral or color-blind patient recruitment and referral patterns that can unintentionally exclude members of certain racial and ethnic groups from receiving care are a byproduct of the current system for health care financing, which incentivizes institutions to care for patients with private insurance, given the higher levels of reimbursement. As described earlier, members of racial and ethnic minority groups are more likely to be underinsured,³⁰ and thus recruitment and referral strategies that prioritize profit maximization contribute to ongoing health care segregation.

It is important to note that racial segregation in health care is not fully explained by poverty or other sociodemographic characteristics and that well-insured and educated patients of color also experience segregated and inequitable care.³⁸ Thus, in addition to addressing the system-level barriers to desegregation described above, physicians, administrators, and other health care leaders must actively work to eliminate bias in clinical practice and discrimination and racism from the health care environment.^{39,40} Patients' experiences of discrimination drive distrust of health care institutions, which can deter them from seeking care in general or care from a specific institution. Examples include an administrator consistently mispronouncing a patient's name or a physician disregarding a patient's cultural or religious dietary practices, as well as more overt acts of discrimination, such as criticizing a patient's accent or using a racial slur. Such discriminatory acts may be particularly common at institutions that care for few patients of color, thereby creating a vicious cycle in which institutions become less and less hospitable and care becomes more and more segregated.

Accountability for Equity

Given the scale and complexity of segregated health care, multiple strategies will be needed to tackle the different contributing factors. Importantly, patients and trusted community members and organizations need to be involved at all steps of the process and compensated for their support. Leadership will need to commit to desegregation. This commitment will entail ending separate trainee and faculty clinical services; addressing insurance contracting and referral network barriers; and examining and rectifying discriminatory policies, as well as interpersonal acts of discrimination. Dedicated and thoughtful physicians and other professionals will need protected time to develop, implement, and measure initiatives aimed at desegregation. Funding for additional programming, such as interpreter services, transportation, food pantries, and legal aid, may be needed to create equal access to care.^{31,34,35,36,41,42}

While many barriers to desegregation can be eliminated at a local level, others will require changes to our national health care system. State and federal policy determine health care compensation, and, without reform, local institutions might struggle to fund the programming needed to successfully end segregation. In this case, well-respected academic health care institutions and clinicians should use their status to advocate for policy and regulatory change at a broader level.

All efforts will need to be coordinated, and, in order to hold everyone accountable, data need to be regularly analyzed and a clear set of metrics and timelines created. Ongoing **oversight by patients, community members**, and other stakeholders, as well as regular assessments of changes in segregation patterns, should inform how programs proceed. Incentives for meeting goals—and, ultimately, for desegregating care—as well as disincentives for enabling the current system to persist should be created.

Segregated care remains a major factor contributing to racial and ethnic inequities in health care outcomes in the United States.³⁸ In order to achieve health equity, we must take deliberate steps to desegregate care, starting with data collection on patient access and outcomes and examination of the myriad factors that contribute to health inequity. This step must be followed by the deployment of well-supported and multifaceted initiatives guided by patients and community members, as well as organizations. These initiatives should address all levels of care—including individual clinicians, practices, hospitals, and medical schools—and factors affecting care, including insurers and US health policy.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Is It Reasonable to Expect Students and Trainees to Internalize Equity as a Core Professional Value When Teaching and Learning Occurs in Segregated Settings?

Adriana Pero and Emily L. Xu

Abstract

Training in a segregated health care system means that health professions students and trainees learn bias and experience helplessness and burnout if they wish to—but cannot—rectify segregated care. When racial segregation is built into training environments, many students and trainees quickly internalize which patients are de facto deemed more worthy of care. Students and trainees who recognize this feature of their professional training as dysfunctional and as an ethical and equity problem need support when reporting inequities and advocating for desegregated health systems. By supporting such efforts, faculty and organizations can help desegregate health care, minimize iatrogenic harm from bias, motivate health equity, and promote equitable access to quality health service delivery.

Case

AB is a student who often hears patients referred to as “clinic patients” when they are insured by Medicaid and as “private patients” when they have more generous insurance coverage. Now rotating in an obstetrics and gynecology unit, AB talks with fellow students about having also observed a norm of asking a laboring patient with private insurance whether they will permit a student to participate in their delivery and a norm of *not* asking a laboring patient insured by Medicaid—often a person of color or fluent in languages other than English—whether they will permit a student to participate in their delivery. Several students agree that they observe differences in how patients are treated and that they are invited, if not de facto required, to participate in routine, long-standing patterns of inequitable care of patients, which makes them feel complicit, morally distressed, and outraged. Some students express fear of reprisals if they question the unit’s practices and their teachers’ perpetuation of inequity and suggest it’s not “worth it” to speak up. Some students, however—even some among those who fear reprisals—also state that they feel terrible about not speaking up. The students exchange ideas and consider how to respond.

Commentary

We stood in the hallway, peering into the room as the attending physician spoke to the patient—a petite, Black woman with metastatic cancer. Despite the patient’s initially declining an unnecessary physical exam by us, the preclinical medical students, the attending physician asked her again if we could examine her. Caught up in the thinly veiled power dynamic between physician and patient, she agreed despite her pain and fatigue. Six students piled into the cramped room as the attending physician began describing the patient, as if she were not laying in front of us. Interspersed among medical jargon, the attending physician mentioned that the patient needed a second chest tube. Alarmed, the patient shook her head nervously, saying, “Not another one.” The attending physician only briefly acknowledged her concern before inviting several students to examine her.

Being early in our training, we could have easily overlooked this patient’s multiple marginalized identities. Yet, after experiencing several similar clinical encounters in addition to learning about endless examples of racial inequity in medicine—from the use of Black bodies for the advancement of medicine¹ to those bodies being targeted for sexual assault²—we cannot discount this pattern of injustice. Who are we, the primarily White, wealthy medical students, allowed to see and examine in our training? How does that affect how we think and talk about patients for the rest of our careers? How can we reject the normalization of segregation?

A Legacy of Separate, Inequitable Care

We began medical school with an idealized view of our future profession. We were quickly jolted into reality when, in our first week, we learned that in many academic medical centers (AMCs),³ including our own in New York City (NYC), privately insured patients and patients with Medicaid or no insurance receive care at different clinics and hospitals. Nationwide, a greater number of Black and Brown patients access health care through Medicaid than White patients, who predominantly have private insurance.⁴ Health care segregation by ability to pay is de facto segregation by race and demonstrates that many health systems still hold the erroneous belief that separate can be equal.⁵ As we learned more, we realized that racial and socioeconomic inequities run far deeper than individual institutions; inequities have been created and sustained through government policies, such as New York State’s General Hospital Indigent Care Pool, which disproportionately allocates funding to private hospitals at the expense of safety-net hospitals that predominantly serve patients of color.⁶

We define *segregated care* as race- and class-based differential treatment resulting from government and hospital policies and practices that intentionally sort patients and distribute resources so as to maximize hospital profits and maintain existing power structures. To take one example, private NYC hospitals prioritize “serving as referral centers” for patients with private insurance, a majority of whom are White in New York State.⁷ Those who are excluded from NYC private hospitals—disproportionately people of color and the working class—are funneled to under-resourced hospitals or forced to wait months to access medical care.⁵ Many private hospitals forgo their **public responsibility as nonprofits** to provide care to patients who struggle to afford health care, instead prioritizing patients whose care is reimbursed at higher rates, thus accumulating financial surplus.⁸ In NYC during the COVID-19 pandemic, one well-resourced health care institution’s satellite hospital that treats uninsured and underinsured patients had a COVID-19 mortality rate more than twice that of the flagship hospital—not because the satellite hospital treated sicker patients or because safety-net hospitals inherently

provide worse care, but because, like many other safety-net hospitals, it was systematically drained of resources.⁹

The segregated system of our training obscures the biases dictating which patients are used for student learning. During Jim Crow segregation, medical schools boasted of the abundance of “clinical material,” or the availability of Black bodies for medical education,¹ teaching medical students to view Black patients as learning material rather than as patients with the right to health care. After the passage of the Medicare and Medicaid Act of 1965, which supposedly forced racial integration of hospitals,¹⁰ Jim Crow racial segregation morphed into a more socially acceptable **segregation on the basis of insurance status**. How much has changed when, in a purportedly “equal” health system, medical students continue to learn primarily on certain bodies?

Contemporary Inequity in NYC

Segregated health care has persisted, despite litigation efforts. In 2006, a report released by the Bronx Health REACH Coalition found that Black and Latino New Yorkers were more than twice as likely to be uninsured as White New Yorkers and that Medicaid and uninsured patients were more likely to receive care in public hospitals.⁵ In 2008, Bronx Health REACH filed a civil rights complaint against 3 AMCs in NYC for segregation on the basis of “source of payment, race, and national origin.”¹¹ An individual involved in the case verbally confirmed in a conversation that there has been no movement on this complaint (January 2022). Despite advocacy groups’ repeated attempts to bring justice to these institutions,^{11,12} to obtain equitable hospital funding,^{13,14} to raise the Medicaid spending cap,¹⁵ and to create a single payer system in New York State,¹⁶ many hospital systems have only consolidated their power by acquiring private practices and forcing hospital closures.^{17,18}

Training in Bias

The assumption of “separate-but-equal” treatment is ubiquitous in medical training. For example, some medical schools continue to attract applicants with opportunities to participate in student-run free clinics that primarily rely on Black and Brown bodies for student learning. Students’ provision of services to patients denied access to medical care by racist health care systems is portrayed as community service and marketed as early clinical exposure, sending the message that antiracism consists of providing a necessary service to people who otherwise would not receive care. Yet, in our experience, students have minimal solidarity with patients who have been stripped of their right to health care, and we know of no organization that acknowledges that these clinics are also a product of a racist and xenophobic system that blocks these patients from receiving health care in the first place.

Training in a segregated health care environment, we struggle to navigate a deeply unethical system. In one survey of medical students, more than half reported witnessing segregated care on the basis of insurance in their clinical training, and the authors speculated that medical students “may see insurance-based segregation as one piece of broader structural racism.”¹⁹ Students witnessing segregated care may fall into learned helplessness, seeing no way to create meaningful change. The dissonance between health systems declaring their commitment to antiracism while upholding modern-day racial segregation creates a medical school atmosphere that forces trainees to make an impossible choice: continually resist the indoctrination of passively learning bias or compromise their values to fit into the mold of academic medicine. With looming residency applications and constant evaluations, the latter can too often be the chosen

path. Students hoping for competitive applications and positive performance evaluations must remain silent and, in doing so, maintain harmful power structures.

Medical schools have a responsibility to support, protect, and train students advocating for desegregated health systems. The coalition of medical trainees we helped found, New York City Against Segregated Healthcare, has pioneered education about segregated care, but education is not enough to encourage students to become agents of change. For students to become advocates, we must train in a system in which fear of retaliation is nonexistent—one in which students are supported when reporting inequities in their training and can witness and emulate clinicians openly refusing to be neutral bystanders of segregation. We envision a training system in which applicant evaluations—from medical school through residency and career promotions—emphasize dedication to fighting for a more equitable health system. Shifting priorities would stabilize the tightrope that students walk between advancing their careers and upholding their values. Creating a more equitable health system must be a priority of medical schools and their associated AMCs.

Rejecting Segregation Normalization

As student activists, we create petitions, host social media storms, and lobby government officials. Working in pursuit of decent treatment of all patients is unpaid, underrecognized, and even more difficult to complete while our clinical education pressures us to accept the current system without question. Moreover, we have encountered resistance to changing the current system. In response to our **calls to desegregate care**, some AMCs have vehemently denied segregation, refusing to acknowledge the sorting of patients on the basis of race or ability to pay. When the patients we see during our training are primarily those with marginalized identities and when our institutions are silent on segregation, we learn that separating patients along racial lines and delivering differential treatment is normal and tolerable. We learn that, in medicine, valuing human life differently is acceptable.

The medical apartheid of our training cannot become the medical apartheid of our future. As trainees, we have the privilege of envisioning an ideal health care system. We imagine a desegregated health care system in which all patients with the same needs or condition are seen in the same location, by the same clinician, with equal wait times for an appointment. AMCs would not benefit from funding structures and policies that disadvantage safety-net hospitals and, by extension, their patients. Patients and community stakeholders would be the drivers of their care, diminishing the power differential between patients, who are often exploited for student learning, and doctors. As long as we are learning to practice medicine in a segregated health care system, we will learn and propagate racism and bias. If we are ever to achieve a truly equitable health care system and training environment, we must desegregate our health care system now.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Academic Health Centers Desegregate Health Professions Education?

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Abstract

One expression of structural injustice in the United States is delivery of health care according to patients' race and insurance status. This de facto segregation in academic health centers limits community organizations' and leaders' capacity to dismantle racism and undermines health equity. This commentary on a case considers this problem, argues why academic health centers are ethically obliged to respond, and offers strategies to do so.

Case

PR is a community organizer who lives in a historically Black neighborhood in a large city near a prominent academic health center (AHC). Despite PR's community's proximity to this AHC, PR and other community members do not seek care there if they can avoid doing so, since they do not generally feel it is "meant for us." PR and others in the community know that world-class clinicians practice at this AHC and that wealthy people from all over the world come to see them. Neither PR nor PR's neighbors have ever seen a physician in this AHC, but they have received care at the AHC's clinics that are staffed by trainees and students who are "volunteering" and doing "service learning."

When PR and other local community leaders were invited to participate in a symposium hosted by the AHC, many referred to their health and health care experiences as segregated, or "2-tiered," and felt condescended to by office staff and clinicians who knew they were insured by Medicaid. In the wake of social, cultural, and institutional responses not only to inequity laid bare by the COVID-19 pandemic in 2020, but also to anti-Black racism and state-sanctioned violence, the AHC is trying to learn how to respond more justly to health needs of its community members.

The AHC considers how to redesign and desegregate its health professions education structures to motivate health equity in communities in which the center and its clinics reside.

Commentary

Racism in American health care is no secret.^{1,2,3,4} As evidence of its scope continues to mount, many institutions have announced efforts to reduce racial disparities.^{5,6,7,8} With

their supply of skilled clinicians, researchers, and financial resources, AHCs might appear well positioned to make—and perhaps even lead—this change. Their seeming abundance of resources, however, is inextricable from academic medicine’s long history of racism,⁹ experimentation on and abuse of Black bodies,¹⁰ and normalization of whiteness at the top of its hierarchy.¹¹ Even the AHCs most committed to racial justice and equity will find it challenging, if not impossible, to simultaneously function within and transform American health care.

We have collectively spent the last decade working to understand and dismantle segregated health care in New York City. Over this time period, we have become increasingly convinced of the need to look beyond the walls of academic medicine for leadership in this effort. The better we understand our health care system, the clearer it becomes, in Audre Lorde’s words, that “the master’s tools will never dismantle the master’s house.”¹²

Still Segregated

Central to understanding our health care system is the realization that there *is* no one health care system. Despite the legal victories of the 1960s—and, in particular, the Social Security Amendments of 1965 outlawing de jure hospital segregation by race¹³—American health care remains segregated. Poor communities and communities of color are provided access to a **different health care system** than that accessed by more affluent, White communities. To take a few examples, Black and Hispanic women with very preterm births are more likely than White women to deliver at New York City hospitals with the highest rates of neonatal morbidity and mortality²; Black patients on Medicare who are treated for heart attacks tend to receive care at lower-performing hospitals than White patients on Medicare, even when they live in the same zip code¹⁴; and, in New York City during the first months of the COVID-19 pandemic, less-resourced intensive care units had higher COVID mortality rates than flagship hospitals.¹⁵ Unfortunately, this system of segregated care represents the status quo. Its ubiquity, however, should not justify its continued existence. A profession with a primary maxim to “do no harm”¹⁶ should not be content with a system that has been shown to disproportionately harm people of color.¹⁷

The reasons for such segregation are complex and multifactorial, but it is clear that health care financing and **insurance coverage** play an important role. Even after the passage of the Affordable Care Act of 2010,¹⁸ Black and Hispanic nonelderly adults are more likely to be uninsured¹⁹ or publicly insured with Medicaid²⁰ and less likely to have employer-sponsored coverage than White nonelderly adults.²¹ Because Medicaid pays relatively less for services than private insurers, hospitals are incentivized to prioritize the care of patients with comparatively generous private insurance,^{22,23,24} limiting people of color’s access to top-performing hospitals, many of which are AHCs. Indeed, a recent investigation by the Lown Institute found that many of the most prestigious AHCs—Mayo Clinic Hospital Rochester, Ronald Reagan UCLA Medical Center, NYU Langone Hospitals, and Massachusetts General Hospital, for example—are among the least equitable hospitals in their communities in terms of patient inclusivity, among other metrics.^{25,26} As a result, safety-net hospitals—those with explicit missions to serve the uninsured and underinsured—must care for those who are left behind. These safety-net institutions treat a concentrated pool of uninsured and underinsured patients, further widening the equity gap between them and the top-performing, revenue-generating hospitals.

Of course, insurance status and reimbursement rates do not entirely explain our segregated health care system. Geographic segregation, often created and enforced through measures such as redlining,²⁷ is also a contributing factor, as evidenced by women often delivering at the hospital closest to their home irrespective of the quality of care provided.²⁸ Unfortunately, the inequities created by geographic segregation are often deepened by health care resource allocation.^{29,30} In New York City, for example, many smaller community hospitals have closed or drastically reduced their services in recent years, shunting patients to the publicly funded NYC Health + Hospitals system.³¹ Many of these changes result from mergers with large AHCs. For example, in recent years Mount Sinai Health System drastically cut the services of Beth Israel Hospital³²; Montefiore Medical Center planned to close Mount Vernon hospital³³; and New York Presbyterian Hospital has sought to replace a needed inpatient psychiatric center at Inwood's Allen Hospital with a more lucrative expansion of an orthopedic spine center.^{34,35} Notably, 18 hospitals have closed in New York City alone since 2003.³⁶ This maneuvering has reduced services for many communities of color, increased patient volumes for remaining community hospitals, and concentrated services at wealthy AHCs.³¹ For every one thousand residents, Queens now has 1.5 hospital beds; Manhattan has 6.4.³¹

Segregated care can also be seen within the walls of AHCs. Frequently, AHCs have separate faculty or attending physician clinics for patients with private insurance, resident-run clinics for those on Medicaid, and sometimes student clinics for the uninsured.^{37,38,39,40} Ostrer et al showed that resident-run clinics at the Icahn School of Medicine at Mount Sinai had longer wait times and less availability than their counterpart faculty clinics.⁴¹ Another study found that patients treated by residents at one Boston AHC network were less likely to be up-to-date on chronic disease and cancer screenings.⁴²

Solutions

Considering the many ways that AHCs are complicit in and benefit from segregated health care, those intent on making change should look outside of hospitals and clinics to learn from and follow the lead of **organizers within the communities** they serve. Historical examples of efforts to dismantle medical racism include the Black Panther Party's medical clinics and the Young Lords' occupation of Lincoln Hospital.^{43,44} The Black Panthers believed that lack of adequate housing, food, and health care were forms of violence, and they sought to provide solutions that were not forthcoming from government and hospitals. Their Ten Point Program called for free health care for Black and all oppressed people, and they implemented clinics and programs that were rooted in their communities.⁴³ In 1970, the Young Lords occupied Lincoln Hospital in the South Bronx, New York, in response to deplorable conditions faced by Puerto Ricans and Black Americans in the community and within the hospital.⁴⁴ Recognizing where medicine fell short, the Young Lords also protested poor sanitation services, initiated community breakfast programs for poor children, and lead tuberculosis screening in East Harlem.⁴⁵ The activism of the Young Lords and Black Panthers proved influential in the creation of the Patient Bill of Rights, expansion of community health clinics, screening for sickle cell anemia, and the federal school breakfast program, among other policies and legislation.^{45,46} To this day, their activism continues to influence how health care disparities are understood and reduced.⁴⁷

Such historical examples of efforts to dismantle racism in health care have modern-day counterparts. In Red Hook, a Brooklyn neighborhood still without its replacement

inpatient facility after the 2013 closing of Long Island Hospital,⁴⁸ the Red Hook Initiative⁴⁹ and partners created a community-based screening tool to identify the medically fragile (eg, seniors and those with chronic medical conditions, especially the underserved or underinsured) during the Covid-19 pandemic. The Kings Against Violence Initiative⁵⁰ in Brooklyn, a violence intervention program that relies on community experts to bridge the gap between a hospital and a community where interpersonal violence is a public health risk, trains hospital staff in trauma-informed care and provides referrals and follow-up services for victims of violence. And, in 2018, medical students at Columbia University Vagelos College of Physicians and Surgeons joined community activists to protest the aforementioned closure of the Allen Hospital Psychiatric Unit.³⁵

Other health care desegregation efforts have broader goals. Medical students, residents, and physicians are collectively organizing alongside community members to demand racial equity and justice within AHCs as part of organizations such as the NYC Coalition to Dismantle Racism in the Health System.⁵¹ And broader movements, such as the Campaign for New York Health, which is fighting for statewide single payer care,⁵² and the Coverage4All campaign,⁵³ which is working for health coverage for undocumented people,⁵⁴ have leveraged community involvement to push for a more inclusive and equitable health care system. Nationally, the Poor People's Campaign builds on Martin Luther King's movement of the late 1960s by adopting equitable, universal health care as one of its key policy principles.⁵⁵ In all of these examples, energy and ideas for reducing segregated care and racism in health care are coming from outside the power structure of AHCs.

Such outside leadership is important, and not only because communities closest to the problems have the deepest understanding of possible solutions. With community leadership there can be flexibility and creativity to reach beyond the standard academic tools of research to the tools of organizing and activism, such as demonstrations and direct action. Community leadership also has the ability to focus solely on the goal of change without the limitations encountered by AHCs and those within them, such as the pressure to publish in academic journals, whose research may fail to benefit the target communities,^{56,57} or the financial constraints enforced by the current system of financing and delivering health care in the United States.

Most importantly, however, is the community's ability and commitment to fight for reforms that match the scale of the problems. Eliminating segregated care will require bold and systemic changes that address both the historical legacies of racism and the current financial structures that entrench it. Solutions proposed by AHCs, however, focus mainly on the former. For example, the Commonwealth Fund highlighted that AHCs' strategies to address racism in health care include important goals, such as auditing school curricula for false claims about race, reviewing race-based algorithms, tracking health outcomes by race, creating reporting mechanisms for racist behavior, investing in training pipelines for students of color, and reexamining institutional policies through an equity lens.⁷ Although important, these strategies will not meaningfully address the fact that minority, uninsured, and Medicaid patients are underrepresented in New York City AHCs⁵⁸ or change the fact that, nationwide, patients with Medicaid have reduced access to medical care.⁵⁹ Addressing inequity will require AHCs to make financial decisions that seem unlikely without broader policy change, including change to how health care is paid for in the United States.

Roles for Academia

Despite the limits on what can be accomplished by AHCs, there are still opportunities for these organizations and those affiliated with them to create a less racist and segregated health care system. In addition to previously mentioned efforts that are largely based within the walls of institutions, AHCs can do more to center community perspectives, energy, and wisdom through reforms to two of their core historical legacies: education and research.

For example, AHCs' selection and training of future health care workers can center community needs and public health by including community leaders. Specifically, AHCs can include community members and leaders on their admission panels to recruit diverse students who come from the communities they seek to serve. In addition, students and trainees can be taught—by compensated community leaders—about the ways in which medical racism impacts the community around them and how their AHC contributes to such problems. Students should also be educated in ethical concepts such as dual loyalty, with an explicit focus on the conflicts caused by loyalty to the success of the AHC within a segregated health care system.

With regard to research, AHCs can follow the well-established principles of participatory-based community research that center equitable partnerships with community collaborators and the dissemination of results to affect change.⁶⁰ Even if publishing takes longer, AHCs can challenge themselves, their researchers, and their students to conduct research that engages the community and is solutions oriented. Institutional review boards and community advisory boards will continue to be important partners in these efforts.

AHCs can also encourage students to use the time they would typically dedicate to academic research to working with community organizations and participating in community movements, even if doing so does not result in standard research products. To be successful, these efforts would need to be matched by commitments from residency programs and other employers to value such efforts in their selection processes. Commitments to community activism and justice work could even be considered in faculty promotions and leadership roles.

Thus, there is an important role for AHCs to play in training health care clinicians and designing systems that will promote equitable health care. However, even with socially just education and research methods, AHCs would still contribute to segregated care as participants in a system that incentivizes it.

Looking Ahead

Dismantling racism in medicine will require transforming the health care system as we know it. Rather than leading this charge, academic medicine should recognize its own limitations as part of the system and seek to play a supportive role. Considering medicine's long history of arrogance and paternalism, adopting such a humble position will be challenging. Ultimately, however, continued reliance on traditional tools of academic medicine to dismantle systems of oppression would lead only to their evolution, not their demise.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Medical Student-Driven Efforts to Incorporate Segregated Care Education Into Their Curriculum

Lindsay Clark, Terence M. Hughes, Ruhee Shah, Ashesh Trivedi, and Leona Hess, PhD

Abstract

US health care is segregated by insurance status and de facto by race; however, traditional models of medical education do not teach students about segregated care, and the authors know of no examples in the literature problematizing segregated care in medical education. To fill this gap, this article describes a student-led effort to disseminate peer-to-peer segregated care education at a single-site, large academic health system in New York City. It also provides educational resources that other student-advocates can adopt to drive curricular inclusion efforts at their own institutions. This article concludes that the primary goal of advocacy to teach segregated care is always desegregation, so curricular inclusion efforts are needed to educate students about the inequitable systems they are entering and to provide them with tools to advocate against such systems.

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Background

Segregation has long been the mechanism through which access to societal resources is limited by race. Structural segregation—the racialized mechanism through which Black Americans are denied equitable access to social goods, including housing, employment, and medical care—persists, despite civil rights legislation outlawing it. In this article, we are concerned with segregation within health care, termed *segregated care*, which, as noted in the 1990s,^{1,2,3} and as continues to be noted in the present day,⁴ manifests as race-based disparities in health outcomes and in access to clinics, physicians, dentists, and pharmacies.

Segregated care also manifests as **health insurance inequities**. In New York State, nonelderly Black adults are more likely to be enrolled in Medicaid and more likely to be uninsured than their White counterparts.^{5,6,7} Furthermore, public insurance eligibility

restrictions—including for undocumented patients, for patients with incomes less than 50% of the federal poverty level, and for adult patients without dependent children—restrict Black Americans from coverage at nearly 2 times the rate of White Americans.⁶ While insurance status is fluid, the available statistics clearly demonstrate that segregating care by insurance status is de facto racial segregation.

Among our ethical responsibilities as medical professionals is to ensure justice in the allocation of medical resources, which requires “nonjudgmental regard and equal treatment for all with similar medical needs.”⁸ While individual clinicians might give the same care to all of their patients, insurance that segregates patients by race, class, and associated proxy markers results in unequal treatment.

Accordingly, this article seeks (1) to describe a student-led effort to disseminate peer-to-peer education about segregated care at a large academic health system in New York City and (2) to provide resources to other student-advocates and medical school administrators looking to educate their students about segregated care.

Segregated Care Curriculum at Icahn

In 2014, Icahn School of Medicine at Mount Sinai (ISMMS) medical students founded the Segregated Care Student Workgroup in order to critically investigate segregated care in both outpatient and inpatient settings across the Mount Sinai Health System. As in many **academic medical centers**, patients with Medicaid were often seen in resident-run clinics, while patients with private insurance were often seen in separate, faculty-run clinics. Through a “secret shopper” study design, ISMMS medical students used a standard script to investigate differences in appointment wait times, one example of differences in care across sites. The study found that callers with Medicaid waited on hold significantly longer to make an appointment (9.8 minutes vs 1.3 minutes on average) and waited significantly longer for a scheduled appointment (13.4 days vs 54.3 days on average) (C. Braschi & L. Ostrer, unpublished data, 2015).

Student-led segregated care work at ISMMS has continued to grow over time. Students interviewed department heads and examined patient satisfaction data in relation to insurance status. Since 2018, student-leaders, including the 4 student authors (L.C., T.M.H., R.S., A.T.), have approached dismantling segregated care through medical education, hypothesizing that training students in a segregated system normalizes the practice and implicitly perpetuates racism. This commitment is particularly important because, as of mid-February 2022, we found no examples of teaching segregated care in medical education in the literature: a PubMed search for *segregated care* in the title or abstract—across all years and data sources—yielded only 9 results, none of which were about medical trainee education or curriculum development.

Description of ISMMS’ Student-Led Curriculum

Since the group’s inception, members of the ISMMS Segregated Care Student Workgroup have provided extracurricular peer-to-peer segregated care education. In early 2020, student-leaders started seeking avenues through which to provide this education as part of the formal medical school curriculum to ensure that it reached all medical students, thereby eliminating the self-selection that often characterizes social justice advocacy.

Throughout 2020, student-leaders, who had built their expertise through involvement in past segregated care research and advocacy, designed and administered a peer-to-peer

curricular and extracurricular education model. They generated presentation content and solicited input from expert faculty working at the intersection of racism, bias, and medicine. All presentations included introductory slides defining segregated care and contextualizing it within New York City (NYC) and the Mount Sinai Health System. This contextualization included quantitative data detailing the percentage of patients by insurance status and race nationally, in NYC, and within the Mount Sinai Health System. All presentations also included quantitative survey data from ISMMS students and residents about their observations of segregated care in clinical spaces and its impact on both care delivery and their perceptions of the health care system. Following the presentations, each session included discussion questions tailored to the audience's particular curricular context—medical student, resident, attending physician, ancillary staff, or all health system staff—to generate further engagement with the material and to identify follow-up action items for students in the audience. A comprehensive list of educational opportunities provided throughout the year is outlined in the Table.

Table. Opportunities for ISMMS Medical Students to Learn About Segregated Care

Educational opportunity	Target audience	Attendance	(Extra)curricular	Presentation goals
Orientation	First-year medical students	Mandatory	Curricular	Define and introduce segregated care.
InFocus 3 ^a	Second-year medical students	Mandatory	Curricular	Prepare incoming clinical students for the experience of segregated care in the clerkship environment.
Chats for Change ^b	All health systems students, faculty, and staff	Optional	Extracurricular	Facilitate education and discussion among students, faculty, and staff across the health system.
Segregated Care Student Workgroup	All medical and graduate students	Optional	Extracurricular	Make students aware of opportunities to participate in research and advocacy outside the classroom.

^a One of 8 week-long blocks provided at ISMMS covering topics outside of traditional preclinical curricula.

^b A health system-wide, interactive discussion series focused on racism and bias in medicine.

Orientation. Student-leaders created and administered a 10-minute peer-to-peer presentation during orientation for first-year medical students. Before their first day of medical school, incoming students learned about segregated care in a session asking them to examine the intersection of their social identities, their roles as medical students, and the health care system. Furthermore, the presentation sought to introduce the Segregated Care Student Workgroup and peer mentors to interested students. (Presentation slides are provided in [Supplementary Appendix 1.](#))

InFocus 3. Student-leaders created and administered another 10-minute peer-to-peer presentation for second-year medical students during InFocus 3.⁹ The presentation focused on providing students the tools to recognize and question segregated care that they would likely experience during their upcoming third-year clerkships, elaborating on action items to guide student engagement. These action items asked students to “identify attending, fellow, and resident clinical role models that are challenging the status quo” and to “reflect on how experiencing segregated care in the clinical environment is impacting your education and personal well-being.” (Presentation slides are provided in [Supplementary Appendix 2.](#)) Following this session, presenting students informally collected feedback from attendees with the goal of improving the presentation year-over-year and further tailoring it to students entering the clinical environment. Open-ended prompts solicited students’ feedback on what they learned

and what could be improved. (The feedback form is provided in [Supplementary Appendix 3.](#))

Chats for Change. Outside the formal curriculum, student-leaders also designed and facilitated a 1-hour optional discussion open to all health system students, faculty, administrators, and staff. The presentation was part of the ISMMS Department of Medical Education's Chats for Change.¹⁰ The presentation titled "Desegregating Care: Thinking Globally, Acting Locally" created a space for open dialogue about actions that individuals could take to challenge systemic and institutional segregated care. Discussion questions included the following: "What is the relationship between segregated care and racism?" and "What are the implications of working/practicing/teaching in a segregated system?" (The presentation, including discussion questions and action items, is provided in [Supplementary Appendix 4.](#))

Vision for Sustainable, Longitudinal Curriculum Inclusion

Mandatory education on segregated care for first- and second-year medical students, with additional extracurricular opportunities for those students interested in learning more, laid the foundation for these students to graduate with the ability to recognize segregated care, articulate its inequities, and implement skills to advocate for desegregation. However, these efforts had numerous shortcomings.

1. Students participating in each educational opportunity only received 20 minutes of mandatory education about segregated care cumulatively, which was insufficient, given the complexity of the topic at hand.
2. Current efforts siloed curricula into 2 distinct sessions administered during the first 2 years of medical school; a longitudinal approach that spanned all 4 years of medical school would be required to provide comprehensive education.
3. All curricula to date were medical student-created and administered. Students were not compensated for this creation, unlike faculty members who create curricula. Furthermore, given constant student turnover, student-administered curricula cannot be sufficiently incorporated into institutional memory without a formalized, institution-driven approach.

To begin addressing these shortcomings, student-leaders met privately with ISMMS administrators in January 2021 to facilitate a conversation about the inclusion of segregated care education into the formal curriculum. The meeting's goals were to review student-led curricular inclusion efforts completed to date, to hear student-proposed ideas for longitudinal and institution-driven curricular inclusion, and to discuss the feasibility of these proposals from the administrators' perspective. The proposed inclusion strategies involved adding discussions, case-based scenarios, and didactics within the framework of existing curricula. (See [Supplementary Appendix 5](#) for the PowerPoint slides guiding this discussion.)

In this meeting, student-leaders received feedback and encouragement to create a written proposal outlining their vision. Administrators encouraged student-leaders to create a roadmap for curricular inclusion across all 4 years of medical school, to create specific curricular objectives, and to pair each objective with metric(s) to assess student mastery. The roadmap comprehensively integrates segregated care into existing sessions on racism and bias, clinical skills, and ethics in accordance with ISMMS'

Medical Education Program Objectives.¹¹ For example, one suggestion involves modifying a session describing minority stress to include how segregation by insurance status could affect minority stress. During the live patient presentations included across preclinical courses, student-leaders suggested “actively and intentionally includ[ing] patients’ insurance status and other examples of racism/bias into patient presentations” (see [Supplementary Appendix 6](#)). Many more specific suggestions are included in the full proposal submitted to ISMMS administration and are provided in [Supplementary Appendix 6](#). At the meeting, student-leaders received a verbal commitment that administrators would incorporate their recommendations in ongoing curricular efforts to strengthen antiracist medical education. Student-leaders and advocates continue to eagerly await institution-led efforts.

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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Training to Build Antiracist, Equitable Health Care Systems

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Abstract

All clinicians should provide high-quality, safe, and equitable care to every patient and community. Yet, in practice, health care delivery systems are designed and organized to exacerbate inequity in access and outcomes, and clinicians are incentivized to deliver unequal and inequitable care in deeply segregated academic health centers that are structured to reify white supremacy. This article investigates the nature and scope of health professions educators' obligations to acknowledge harms of segregation in health care as widespread, unjust, iatrogenic, and preventable.

Causes of Segregated Care

Physicians and, indeed, all health professionals should provide high-quality, safe, and equitable care to every single patient and community. Health care systems should commit to **antiracist practices and processes** to ensure that physicians and other health care professionals are in fact able to provide equitable care.¹ In practice, however, medicine and health care have been designed, organized, and incentivized to deliver highly unequal and inequitable care, which has contributed to widespread, unjust, and preventable harm to and outcomes for individuals and communities that have been historically marginalized.² These far-reaching and persistent manifestations of white supremacy—the false hierarchy of human value based on the color of one's skin—inspired one graduating class at the University of Pittsburgh School of Medicine to create a modern-day Hippocratic Oath. Their oath acknowledges the “fundamental failings of our health care and political systems” in caring for historically marginalized communities and communities excluded from Western health systems and calls for an “enduring commitment to repairing the injustices against those historically ignored and abused in medicine: Black patients, Indigenous patients, Patients of Color and all marginalized populations who have received substandard care as a result of their identity and limited resources.”³

Data indicate that the US health care system is highly segregated and inequitable.^{4,5,6} The root causes of these health inequities include, but are not limited to, a pervasive culture of white supremacy in academic health care and research,^{7,8} clinicians' and

employers' implicit biases,^{9,10,11} structural and color-blind racism in health care policies and practices,^{12,13} and a **2-tiered payment system** that paradoxically reimburses the least for the patients with the most socially complex needs and structural vulnerabilities.¹⁴ The result is that patients who have been historically marginalized and excluded from health care (eg, white patients with low incomes and Black, Indigenous, and Latinx patients) are offered a constricted set of choices, as affluent “elite” health centers effectively close the doors to them through conscious contracting decisions and capital investments.^{15,16,17} The overall effect is a tale of 2 unequal societies across the United States, both within our cities and between urban and rural areas, whereby richer and poorer hospitals serve richer and poorer populations, respectively, with (unsurprisingly) very different results.⁵ This article discusses the ways in which institutions that support health professions education have perpetuated and supported inequitable health care and identifies opportunities for educators to address health inequities through their work with students, trainees, and health system leadership.

Failures to Address Inequity

Medical education has historically leaned into and harmfully normalized racial and socioeconomic inequity. Although hospitals no longer explicitly admit patients to different hospital towers or wards based solely on the color of their skin,¹⁸ Black, Latinx, and Indigenous patients, as well as white patients with low incomes, continue to be **differentially funneled** to under-resourced and underinvested safety-net centers and resident clinics, where trainees are encouraged to gain experience working with these “complex” patients.^{19,20,21} These clinics—and the health care teams that staff them—differ from private practices and faculty-only clinics within the same academic health centers both in appearance and in the resources available to support patient care within their walls.

The contemporary reality of inequitable health care is exacerbated and perpetuated by a lack of standardized medical education on the historical and present-day root causes of segregation in health care and the structural causes of health inequities. From its earliest days, this nation has been segregated based on false notions of racial hierarchy.²⁰ Beginning with colonist settler theft of Indigenous lands, government-sponsored genocide, and removal and segregation of Indigenous peoples into circumscribed territories²²—and continuing through the 20th century government-sanctioned racial segregation of neighborhoods, known as redlining²³—US cities and states have been designed to separate white communities from people of color. These racist policies were created and are maintained by local and federal government agencies, banks, and other entities through exclusionary zoning, public housing policy, discriminatory practices in homeowner loans and banking, gentrification, and displacement.²³ This geographic segregation continues to reinforce between-hospital racial segregation and inequitable health outcomes today.^{5,6,24,25,26,27,28,29} Neighborhood segregation, however, fails to explain the more insidious ways in which segregation persists *within* hospitals. Through insurance status and other facets of institutional racism—as well as health care professionals' biases, behaviors, and, in some cases, racist ideas³⁰—racial inequities in access to care, treatment, and outcomes remain the status quo in hospitals in the United States today.²⁰ These unjust differences in care are exacerbated and reinforced by the ongoing segregation of the health care workforce.^{19,31}

Yet, for far too long, little of this de facto segregation has been discussed or taught in mainstream medical education, in part because of the systematic exclusion of people of color, particularly Black and Indigenous physicians, from leadership roles in medical

education and health care organizations. Despite evidence that greater segregation of care teams is associated with higher mortality rates for Black patients³¹ and that diverse care teams lead to better health outcomes and organizational performance,³² white privilege and the erosion of even modest diversity gains through affirmative programs^{33,34,35} have kept higher education institutions, and thus physician groups, disproportionately white. The consequence is that many physicians and medical educators remain woefully ignorant of racial injustice and inequities in health care. As such, they frequently lack the knowledge, skills, lived experiences, and expertise to teach medical students how to effectively identify, challenge, dismantle, and redesign the systems and structures of power and oppression that adversely affect their patients and their patients' communities.

In the face of these challenges, medical students and other trainees have started to effectively organize and mobilize to demand more of their educators and institutions. Some key examples of this mobilization include the White Coats For Black Lives movement³⁶; the recent passing of antiracist resolutions in the American Medical Association's House of Delegates,³⁷ many of which were originally submitted for consideration by members of the medical student section; student advocacy supporting the elimination of racist medical algorithms³⁸; reimaging of medical school curricula, beginning from an antiracist and abolitionist perspective³⁹; and student leadership identifying and seeking to redress harms arising from unequal access to services.¹² Focused attention on these issues has led to structural and policy changes that have advanced equity and antiracism in broad areas of patient care,^{8,40} although not without resistance.^{41,42}

Educators' Roles

Because the challenges of segregation in health care and the deficits in medical training are complex and multifactorial, solving them will require sustained, cross-sector, collective action. Health professions educators can do their part by working together and committing to educate themselves about strategies to eliminate structural drivers of health inequities; resources have emerged in recent years to do so.^{43,44,45} They must then **elevate these issues** and ask students to consider the ethical and fiduciary obligations of health professionals and systems to historically marginalized and oppressed patients and communities.

To begin, faculty must learn to identify and acknowledge when segregated care occurs. Recognizing segregated care will require listening to and learning from patients, students, trainees, and clinicians who identify the ways in which segregation manifests. When structural inequities go unacknowledged, students and trainees implicitly learn that separate and unequal care is justified and even acceptable, both between and within facilities. To ensure that students and residents avoid internalizing harmful messages about the relative worth of different patient populations, faculty must explicitly address the ways in which care systems segregate patients. They must point out the inconsistencies between performative statements of antiracism and organizational behaviors that maintain racist and inequitable care within and beyond the hospital walls. Furthermore, faculty must take seriously concerns raised by residents and students about inequities and racist practices, policies, and systems, and they must support students and trainees in identifying ways to redress these concerns.⁸ When the most junior members of the profession see with fresh eyes the injustices to which others have become accustomed, faculty must challenge their own apathy and resist resignation to the status quo. Some institutions have begun to address inequities

identified by students and trainees using restorative justice approaches to addressing past harms. One such actionable framework designed for health system responses to structural inequities and segregated care is the Healing ARC (acknowledgment, redress, and closure).⁸

Health professions education and training must likewise equip tomorrow's health care leaders with the skills to identify and eliminate inequities and to remake health systems. It must foster longer-term transformational thinking rooted in social change and antiracist practice, as well as a sustainable and thriving, diverse workforce.^{46,47} Addressing segregated care depends on building individual and team capacities, deepening knowledge, implementing new approaches and methods of practice and evaluation, and building an institutional culture rooted in equity and antiracism. Change must happen at all levels of medical education and requires faculty equipped to lead this work. Educators must emphasize the role that all faculty—not just those who primarily focus on equity, diversity, and inclusion efforts and actions—play in addressing injustice in health care. Mandatory faculty development and education to develop shared understanding of structural racism and other systems of power and oppression, along with guidance and mentoring of faculty who are newer to these concepts, can create shared frameworks and methodologies for creating educational content and presenting it to trainees.^{48,49}

In approaching these topics, medical school faculty must also avoid tasking Black, Latinx, and other physicians of color, who bear the burden of the minority tax,^{50,51} with this work. Curricula must incorporate longitudinal education and mentorship to address the structural drivers of health—explicitly naming racism and other systems of power and oppression—as part of preparing the next generation of clinicians to both identify and dismantle systemic inequities and to create equitable systems. Structural competency curricula have been developed and are available for use by any institution⁵²; some schools have begun to incorporate strategies to teach structural competency not only in the classroom but also by bringing students out of the proverbial ivory tower.⁵³ Many residency programs have also begun incorporating antiracism and structural competency education into their core curricula.⁵² Increased awareness of conscious and unconscious biases and structural drivers of health can increase the likelihood of upstander interventions, including interrupting microaggressions as well as recognizing and addressing racist policies and practices.⁵⁴ We anticipate that as antiracism efforts in medical education continue to develop, further evidence of their benefits and of effective strategies for advancing equity in these spaces will emerge. For example, several residency programs have modified recruitment strategies with the explicit aim of their residency classes mirroring the diversity of their patient populations.^{55,56,57,58} Some have found success through providing training for selection committee members in structural drivers of educational achievement and holistic review techniques,^{55,59} which is confirmed by the first author's personal experience. Faculty education and structural changes to recruitment processes could similarly be focused on addressing other areas of inequity that lead to segregated care and segregated care teams. While a few dedicated fellowship training programs exist to support future leaders in health care equity,^{45,60,61,62} antiracist and social justice education must be embedded in every level of the medical education system.³⁹ The recently published diversity, equity, and inclusion competencies developed by the Association of American Medical Colleges⁶³ are a foundational component of this effort and must be rapidly integrated into medical schools and training institutions; validated means of measuring these competencies must be developed and deployed.

Engaging Health System Leadership

Faculty must also challenge hospital and university leadership to initiate transformative change that moves beyond the performative antiracist statements that leadership has issued in recent years.^{46,64} Ensuring accountability through structured evaluation of programs meant to address segregated care and other manifestations of racism is equally crucial; several new frameworks exist and are now being used by institutions leading work to advance equity within their walls.^{8,65}

Health care institutions can and must address segregation not only of patient care, but also of hospital staff. Guidelines for antiracist actions that executives should undertake to address these structural inequities have been developed and are available to guide health system leaders.^{65,66,67} As a first step, leaders must correct gross disparities in employee compensation, commit to paying a living wage for all employees and contractors, and provide a comprehensive benefits package that includes health insurance coverage for all health system employees. To do so, they can and should examine employee compensation, advancement, and retention data stratified by race and other key social identities to identify priority areas for policy change that would support equity within faculty and other employee groups. Hiring, promotion, and retention of diverse faculty is critical to ensuring that both learners and patients benefit from the expertise, knowledge, and lived experience of a diverse physician workforce. Equally important for health system leadership to address are the racial inequities in the non-faculty staff. Higher-paid positions—including administrators, physicians, nurses, and other professionals—are disproportionately filled by white professionals, while people of color are overrepresented in lower-paid roles, such as security guards and food services.⁶⁸ Creating pathways for economic advancement, career development, and promotion within and across health systems—particularly for the lowest-wage workers who are disproportionately people of color—are additional strategies for fostering diverse health care teams.

Simultaneously, today's leaders must address structural factors that perpetuate segregation to enable the delivery of equitable care both within and between institutions. To fail in this regard ensures both ongoing harms to individuals who have been marginalized (in the form of avoidable deaths and delays in diagnosis and treatment) and devastating moral injury for clinicians who bear witness to these harms while being forced to remain complicit in systems that perpetuate them. For example, medical educators and health system leaders must support health care finance reform that incentivizes equitable care and eliminates the structural incentives that lead to segregated clinics, wards, care teams, and health systems. It is critical to note that the involvement of trainees and students in the evaluation and treatment of some patients (and not others) within training institutions is not the root cause but rather a symptom and consequence of segregated, inequitable care within health systems. If differential clinician and organizational compensation based on insurance were eliminated, such that insurance status no longer functioned as a gatekeeper to certain clinicians and health care services, other structural disincentives to equity could be substantially mitigated. Equal compensation for care—for example, through a single payer system—could allow nonclinical resources, including administrative support, physical space, and ancillary services that address adverse social drivers of health, to be equitably distributed to patients regardless of whether a faculty or resident physician provides clinical care.

If health professionals value the life of all patients equally, they must relentlessly pursue reform and seamless integration of payment systems, clinical structures, health care teams, and clinical education. Although achieving health equity will require broad and deep change in nearly every facet of the health care system, practical first steps can be taken at the institutional level, and large-scale change can be catalyzed by clinicians demanding that health care be equitable.

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HEALTH LAW: PEER-REVIEWED ARTICLE

Using Civil Rights Law to Undermine Profitability of Ongoing Racial Segregation in Health Care

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Abstract

In 2008, New York Lawyers for the Public Interest filed a civil rights complaint with the New York State Office of the Attorney General on behalf of its client, Bronx Health REACH. This complaint asserts that 3 prestigious New York City (NYC) health care organizations' outpatient clinics maintain systems of care that are separate, unequal, and segregated by race. This article considers health care segregation's past, present, and future; specifically examines 1990s and 2000s-era civil rights complaints in NYC; and offers strategies to improve equity and outcomes in NYC that can be applied in health networks nationwide.

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Yesterday

To think about segregated health care now, one has to remember the past.^{1,2} Between the ending of the Civil War in 1865 and the Civil Rights Act of 1964, there was a long interregnum.³ During the Reconstruction period from 1865 to 1877, the US government passed constitutional amendments to end slavery,⁴ guarantee equal protection,⁵ and protect voting rights based on race and color.⁶ But the White response to emancipation was insurrection. From 1881 to the 1960s, US states and localities passed reactionary laws restricting the rights of people of color in every facet of ordinary life—education, work, and, of course, health care.^{7,8} In the medical field, the influential **Flexner Report** of 1910 paved the way for improving medical education—but only for White patients and White doctors. The report put it bluntly: “A well-taught negro sanitarian will be immensely useful; an essentially untrained negro wearing an MD label is dangerous.”^{9,10}

Around the same time, the brilliant sociologist W.E.B. Du Bois edited a 1906 study entitled *The Health and Physique of the Negro American*.¹¹ He noted that in hospitals “in the South they have separate wards or distinct institutions”¹¹ and that, in the North, it wasn't much better. In the Colored Hospital and Home in New York City, for example, Black patients could be admitted but could not be treated by Black doctors.^{11,12,13} But segregation ran deeper still. Du Bois' study was a detailed examination of the equality of

Black people and White people and rejected the notion that the former were inferior to the latter.

The Conference [for the Study of the Negro Problems at Atlanta University on May 29, 1906] does not find any adequate scientific warrant for the assumption that the Negro race is inferior to other races in physical build or vitality. The present differences in mortality seem to be sufficiently explained by conditions of life; and physical measurements prove the Negro a normal human being capable of average human accomplishments.¹¹

While it might seem shocking, “inferiority” appears in a different guise today, in this century. Historically, it was assumed that race was “a reliable proxy for genetic difference”¹⁴ and that people of color “experienced greater genetic susceptibility to disease.”¹⁵ We now know that racial health disparities are not genetic and inherent but caused by social factors and contingent, and there is a growing movement of health care professionals, researchers and academics, and lawyers and communities who are running against the current of inequitable care based on race.

Today

Bronx Health REACH (REACH) and New York Lawyers for the Public Interest (NYLPI) have taken a stand against segregated care. Founded in 1999, REACH comprises community- and faith-based organizations and health care clinicians with a mission to end racial and ethnic disparities in the Southwest Bronx.^{16,17} NYLPI is a public interest law firm with lawyers and organizers working on behalf of the communities that care about health justice, disability rights, and environmental justice in New York City.¹⁸ The Southwest Bronx—mostly Black and Brown families—has poor health outcomes compared to New York City as a whole on every metric: infant mortality, premature death, life expectancy, and chronic conditions.¹⁹ Perhaps unsurprisingly, people of color in New York City have a high uninsured rate. The New York City Department of Health and Mental Hygiene reported that, in 2012, 19% of Black adults, 31% of Hispanic adults, and 20% of Asian and Pacific Islander adults were uninsured compared to 12% of White adults.²⁰

In 2008, NYLPI (with which I was affiliated at the time), on behalf of the client, REACH, filed a civil rights complaint with the New York State Office of the Attorney General against 3 prestigious New York City hospitals—New York-Presbyterian, Mount Sinai, and Montefiore—each of which is a short subway or bus ride away from the Southwest Bronx.²¹ The assertion was that these hospitals maintained 2 separate and unequal systems of outpatient clinics, sorting patients based on payer source and resulting in disparate treatment of patients based on race and national origin. It was the existence of such unequal segregated care that gave rise to the separate-but-equal clause of the Hill-Burton Act and Title VI of the Civil Rights Act of 1964, which conditioned hospital federal funding on nondiscrimination.^{22,23}

First, there was precedent. In 1994, the New York State Department of Health and New York State Division of Human Rights began an investigation of Mount Sinai and Presbyterian hospitals when a number of maternity patients accused these hospitals of sorting patients in the maternity ward based on payer and, as a result, race.²¹ During the hearing of the investigation, the hospitals shared one interesting kernel of information: “They said their previous practice—which they have since abandoned—was intended to place Medicaid patients as close together as possible to provide more efficient care, since those patients did not have private physicians and relied on resident physicians in training for most of their care.”²⁴ Why, we asked, did Medicaid patients, primarily people of color, have access only to residents rather than fully trained attending physicians who

are more seasoned and can detect problems earlier and faster? And if this happened in inpatient hospitals, could the same thing occur in outpatient settings?

REACH's members seek treatment for diabetes, heart disease, and cancer at outpatient clinics, where community members experience frequent disruptions and uncertainties in accessing care, as well as poor quality and delivery of care. In developing our complaint, we focused on outpatient pathways to endocrine and cardiac care, given the prevalence of diabetes and heart disease in the community, and we conducted specialty surveys on the referral practices of 3 major teaching hospitals in or near the Bronx.²¹ Community members volunteering as testers were given a uniform script and scheduled to make calls to physician referral services on staggered shifts over a 2-month period.²¹ They asked for a referral for a relative whom they said would pay for care with Medicaid, private insurance, or out of pocket.

Testers took note of the following during each call: whether they were referred to a physician to receive an evaluation of their medical concern or instead to a clinic; the names and numbers of all physicians to whom they were referred; and the numbers of all clinics to which they were referred. In cases in which the caller was referred directly to the clinic, a follow-up call was made to determine the type of health professional who would treat the patient at that location (faculty physician, attending physician, fellow, resident, or medical student); whether the patient would have access to the physician for after-hours or weekend care or would be referred to the emergency department; and whether the physician would follow up with the patient's primary care physician.²¹ The result: testers who said that the relative about whom they were calling was on Medicaid uniformly were **referred to clinics** rather than faculty practices; were referred to residents rather than fully licensed faculty or attending physicians; were offered no access to help on the weekend or after hours other than the emergency room; and were offered no follow-up with their primary care physician.²¹

These findings are disconcerting because of the impact over time of segregated care on individuals and their bodies. In our complaint, we added stories from community members experiencing such care. Here is one vignette of a community member who learned that she had cancer:

Vanessa realized that her condition was allowed [to] disintegrate as much as it did because she was not able to get an accurate diagnosis and treatment early enough in the onset of the disease. Bouncing between her clinic and the emergency room, she was repeatedly told to simply eat healthier instead of being properly examined to determine if there was a more serious problem. Vanessa thinks her concerns were dismissed out-of-hand because there is a pervasive negativity among staff in clinics and emergency rooms toward Medicaid patients. She recalls that a nurse once told her: "well, you know you people ... with those, you know, managed care Medicaid, you guys don't really take care of yourselves anyway... [and] that's how all of the doctors feel about you guys anyway, because ... if you really took care of yourself you wouldn't have managed care—you wouldn't have Medicaid."²¹

In other words, Medicaid is now a proxy for race and an indictment of Black and Brown communities in the health care setting. If you are a person of color who is not Asian, you are more likely to have Medicaid than if you are a White person, and people of color are treated as second tier in the hospital setting precisely because they have Medicaid rather than private insurance.²⁵ When Medicaid was first enacted in 1965, "Southern states were resistant to federal overreach due to immense changes brought by the civil rights legislation. A state-run program [with federally funded assistance] presented a solution, limiting federal involvement while allowing states to continue running health programs for low-income residents," often minimally and to the disadvantage of people

of color.²⁶ For example, studies examining nursing home segregation based on race and Medicaid have found that, on several metrics, Black residents lived in poorer-quality nursing homes than White residents and that nursing home care in southern and Midwestern states was de facto segregated.^{27,28} The result was stark differences in care that were palpable to patients like Vanessa.

Tomorrow

Our vision for the future is that medicine is integrated and equal. At the state level, the staff of then-Attorney General Andrew Cuomo showed an initial interest in our complaint but later reversed course and claimed that our complaint on “administrative difference”—for example, the difference between seeing a licensed doctor for cancer care as compared to a resident—could be “thrown out” by a court and not survive a legal motion to dismiss.²⁹ At the same time, however, hospital lobbyists in New York City poured millions of dollars into the coffers of Andrew Cuomo and his election campaigns for attorney general and governor until his resignation in 2021.³⁰ The complaint is still active, albeit dormant, and the new attorney general, Letitia James, could choose to revive it.

At the federal level, we have seen positive steps toward equity with the 2010 Affordable Care Act (ACA) functioning “as a stealthy civil-rights achievement of the Obama presidency, promising to make health care less of a financial burden, end disparities in health-care coverage, ease barriers to access for people of color, and subsidize preventative health-care services that proved especially lacking in black neighborhoods.”³¹ The equity promise of the law was severely damaged by the Supreme Court decision in 2012 that allowed states to opt out of the **Medicaid expansion**.³² But President Biden now has another chance to eliminate health disparities if he chooses—for example, by expanding “Medicaid-funding services such as food and housing that the government insurance plan hasn’t traditionally offered.”³³ There are also possibilities on the state and federal legislative front.^{34,35,36}

The story of health care in the United States is still being drafted. Will it be equal and just to communities of color, or will it remain unequal and separated? Before he produced his searing report on health care across the country, Du Bois had a personal story to tell on health care and race. His 2-year-old son, Burghardt, contracted diphtheria.³⁷ Du Bois searched for the two or three black doctors in Atlanta with no success, and the White doctors refused to treat his son. While diphtheria is serious, it was curable, even in the mid-1890s.³⁸ Nevertheless, Du Bois’ son died 10 days later simply because he and his father were Black people. Can we change that outcome in 2022 and beyond? Through continued discussions regarding institutional racism, events such as those recollected by Vanessa and Du Bois can be prevented.

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POLICY FORUM: PEER-REVIEWED ARTICLE

What Should Antiracist Payment Reform Look Like?

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Abstract

Racism reduces eligibility for health insurance and access to high-quality care for people of color in the United States, and current payment structures exacerbate the resultant de facto racial segregation. Payers and health plans do not adequately support and incentivize clinicians and health care delivery organizations to meet the health needs of minoritized communities. This article describes foundational work needed to create an antiracist culture of equity; the Roadmap to Advance Health Equity; and specific, actionable antiracist payment reform strategies, including increasing access to and the scope of health insurance coverage, antiracism accountability in managed-care contracts, support for the safety-net system, strengthened nonprofit hospital tax status requirements, and payment incentives to advance health equity. Antiracist payment reforms have great potential to desegregate health care systems and to ensure that everyone has a fair opportunity to receive good health services and optimize their health.

Advancing Health Equity With an Antiracist Lens

In his 2005 commencement speech at Kenyon College, writer David Foster Wallace began: “There are these two young fish swimming along, and they happen to meet an older fish swimming the other way, who nods at them and says, ‘Morning, boys, how’s the water?’ And the two young fish swim on for a bit, and then eventually one of them looks over at the other and goes, ‘What the hell is water?’”¹ Those fish couldn’t contemplate the water because it was always around them. When we contemplate how we navigate the waterways of our own day-to-day lives, we realize that we’re just one being in a wider world of interconnected lakes, ponds, and puddles. Yet, as Camara Phyllis Jones opines: “Fish swimming in water may be unaware of the water, but the water in which they swim can be clean or polluted.”² In the United States, our waterways are the systems and structures that constitute our society, and they’ve been polluted with racism. Their byproduct is a separate and unequal health care system for marginalized populations and one-size-fits-all approaches that fail to meet their needs. Unlike fish who have little choice but to live in a polluted body of water, we have the opportunity to change the environment around us. This article first discusses making the case for a culture of equity and reforming the medical payment system so that it becomes steeped in principles of antiracism to materially ameliorate the imbalances in

our segregated health care system. It then discusses specific, actionable antiracist payment reform strategies.

Creating an Antiracist Culture of Equity

Race is a social construct. Our societal norms privilege and reward those who possess or can approximate whiteness.³ Sociologists Michael Omi and Howard Winant argue that “race has been a master category, a kind of template for patterns of inequality, marginalization, and difference throughout US history.”⁴ Racism is not limited to easily identified bad actors. It manifests personally, institutionally, and structurally.⁵ Structural racism has caused inequities in wealth, income, education, housing, incarceration, and employment, leading to and exacerbating health disparities.⁶ For example, enslaved African Americans lost nearly \$20.3 trillion in unpaid wages, a theft that reverberates within the Black community today.⁷ US President Abraham Lincoln signed the Homestead Act into law in 1862 to disburse ancestral lands.⁸ By 1934, the Homestead Act and federal Indian policy had gifted more than 270 million acres of Native American land to individuals.⁸ In order to create change, one must understand how historical acts of racism and colonialism influence the contemporary moment.

Structural racism can affect the health of racially marginalized populations through economic and social drivers of health (SDOH). For example, in many municipalities, redlining systematically denied Black homeowners good mortgage rates in desirable neighborhoods.^{9,10} Therefore, a disproportionate number of Black people live in food deserts where it is difficult to access affordable fresh fruits and vegetables.¹¹ Lack of access to healthy foods leads to higher rates of obesity, diabetes, and cardiovascular disease.¹²

Because the health care payment system was created within a society rife with structural racism, meaningful reforms require being **actively antiracist**, or “accepting that all actors in a racialized society are affected materially ... and ideologically by the racial structure.”¹³ Reforms must avoid adopting a mantra of color-blindness, which ignores how racism and racial bias disproportionately impact people of color. Antiracist payment reforms in the health insurance industry and public policy, however, have been limited because the nation has not truly valued and prioritized advancing health equity, nor has it intentionally adopted an antiracist lens. Therefore, we offer practical strategies that organizations can implement to create a culture of equity and restructure payment systems to advance health equity that they can tailor to their individual contexts.

Physicians and other health care professionals should advocate within their organizations to create a culture of equity and for antiracist payment reform^{14,15} (see Figure 1). While specific approaches may vary for each organization, universal starting points apply to all. Organizations should either have specific in-house expertise or consult an outside partner skilled in uncovering how racial bias can be reinforced within poorly designed structures, policies, and rules. Organizations should provide meaningful decision-making power and support to internal diversity, equity, and inclusion (DEI) staff. In addition, all employees at all levels should receive training in how to implement an antiracist lens in their day-to-day work and policy decisions.^{16,17,18}

Figure 1. Create an Antiracist Culture of Equity

1. Require ongoing diversity, equity, and inclusion training for the entire health care delivery organization using analytical frameworks that increase cultural competency:
 - a. *Critical consciousness*: encourages sociopolitical analysis, civic engagement, and social action.¹⁹
 - b. *Intersectionality*: articulates overlapping, multiple systems of oppression (eg, racism, sexism, heterosexism).²⁰
 - c. *Relational cultural theory*: facilitates discussions and relationships; uncovers bias, prejudices and power imbalances; helps lead to compassion and justice.²¹
2. Empower diversity, equity, and inclusion personnel to spearhead and guide initiatives that support racially marginalized employees, patients, and community members.
3. Ensure that the entire health care community, including patients and their communities, have the opportunity to meaningfully participate in decision making.

In our DEI work at the University of Chicago, applying relational cultural theory with an antiracist lens²² has helped us cultivate a culture of equity. Developed by Jean Baker-Miller, relational cultural theory prioritizes growth-fostering relationships. It emphasizes discussions and relationship building, uncovering bias and power imbalances, and encouraging compassion as well as racial and social justice.^{21,23} Application of relational cultural theory would include each employee having the opportunity to provide feedback informed by their job function and experiences with patients and communities. Lessening the impact of norms and processes that reflect a culture of white supremacy—such as defensiveness, discomfort with conflict, power hoarding, and paternalism—is essential to ensure that organizations adequately address the needs and concerns of racially minoritized populations.²⁴ These norms can make payment reform difficult, if not impossible.

Implementing Antiracist Payment Reform

The Robert Wood Johnson Foundation Roadmap to Advance Health Equity outlines a process by which payment intentionally supports and incentivizes care transformations that address medical and social issues driving health and health care inequities (see Figure 2).^{14,15,25}

Figure 2. How to Implement the Roadmap to Advance Health Equity

1. Stratify clinical performance data by race, ethnicity, and other social risks.
2. Perform a root cause analysis of disparities in partnership with patients and communities.
3. Design and implement care transformations that address root causes of disparities in partnership with patients and communities.
4. Create a culture of equity.
5. Reform payment to support and incentivize these equity-focused care transformations.

With regard to Figure 2, Steps 2 through 4, payers, health plans, and health care delivery organizations must engage patients and communities in identifying health disparities and, instead of simply soliciting feedback, create avenues for those communities to enact meaningful, lasting change. Evidence-based interventions known to reduce racial and ethnic disparities in care and outcomes include culturally tailored approaches, comprehensive team-based care, and partnering with community health workers.^{15,25} Care delivery systems that extend service hours beyond the standard workday to accommodate those without the flexibility to take time off from work might also reduce inequities.

With regard to Figure 2, Step 5, an antiracist approach to payment reform is, by definition, proactive, seeking out and naming racist practices and implementing antiracist solutions (see [Supplementary Appendix](#)). Below, we describe 6 ways to implement antiracist payment reform.

Increase access to quality health insurance. Racism reduces access to care and the quality of care that people of color receive. For example, racially marginalized groups are overrepresented in the Medicaid system, where they often have difficulty accessing care because Medicaid reimbursement rates are frequently below those of commercial insurers.^{26,27} In fact, the Medicaid program was enacted in 1965 on a foundation of structural racism. As part of negotiations over the creation of the Medicare and Medicaid programs, President Lyndon B. Johnson cut a deal with Southern congressmen by which Medicaid would be a joint federal-state program, enabling states hostile to civil rights to retain significant control over program benefits and funding as well as the health of the disproportionate numbers of Black beneficiaries.^{28,29} Jamila Michener writes: “Medicaid is racialized, despite being facially colorblind, because race has been a central factor in shaping policies, discourse, design, implementation, and perceptions of it.”³⁰ Thus, an antiracist—not a color-blind—approach to payment reform is imperative for meaningful change.

Barriers to care also persist for people of color in the Medicare system, partly because of the maldistribution of health care resources. An analysis of a 2001-2002 survey found that about 20% of primary care physicians accounted for 80% of visits by Black people nationwide.³¹ Those physicians were more likely to report being unable to provide high-quality care, elective admission to hospitals, and access to high-quality subspecialists and diagnostic imaging.³¹ An antiracist approach to payment reform would improve the distribution of and access to primary and specialty care by providing incentives to care for underserved populations and to cover telehealth.

Improve the scope of insurance coverage for medical and social needs. Many insurance plans provide limited or no coverage for interventions to address patients’ social needs and SDOH.³² Interventions for marginalized populations are frequently held to the higher bar of cost savings rather than value. For example, the Affordable Care Act of 2010 required budget neutrality or cost savings for models of the [Center for Medicare and Medicaid Innovation](#) (CMMI) to be continued even if there were big payoffs in health with slightly more money included.³³ These criteria limit what innovation is possible, even as the CMMI constructively identifies advancing health equity as a priority.^{34,35}

Make antiracism nonnegotiable in managed-care contracts. State Medicaid agencies should require managed-care health plans to implement antiracism measures with accountability as nonnegotiables in contract agreements.^{36,37,38,39} The medical director of Minnesota Medicaid and MinnesotaCare, Nathan Chomilo, argues: “Addressing structural racism, promoting anti-racism, and capturing and measuring health equity are part of the expectations for any managed care plan who’s serving our enrollees.”⁴⁰ One way for organizations to demonstrate similar expectations would be to require potential vendors to answer questions such as: How does your organization explicitly implement antiracist measures? What correctives have your organization implemented to become antiracist, and what is your plan for maintaining and improving upon those correctives?

Another potential reform that state Medicaid agencies could enact would be to require racial equity impact assessments of plans’ policies and actions, including measures of

racial discrimination. Jamila Michener developed a Racial Equity Framework for Assessing Health Policy, which includes examining disproportionality in the benefits and burdens of policies across racial and ethnic groups and the extent to which communities of color influence policy.⁴¹ Another practical tool is the City of St Paul Department of Safety and Inspection's Racial Equity Assessment Worksheet, which helps organizations plan and analyze policies and programs in 5 steps: (1) setting outcomes, (2) involving stakeholders and analyzing data, (3) examining benefits and burdens, (4) developing short- and long-term strategies to eliminate inequities, and (5) raising racial awareness and being accountable.⁴² These tools can all serve as blueprints for holding vendors and states accountable.

Strengthen support for the safety-net system. It is critical to support, rather than penalize, provider organizations caring for racially marginalized populations.^{25,43} For example, initially Medicare's Hospital Readmissions Reduction Program, which tries to link payment to quality of care, disproportionately hurt the finances of safety-net hospitals caring for patients with high social risk and increased readmission rates for Black patients.⁴⁴ Safety-net hospitals that care for a higher percentage of racially marginalized populations could do worse in pay-for-performance programs than non-safety-net hospitals, leading to decreased resources, which could in turn lead to worsened care and lower revenue in future pay-for-performance cycles. Some safety-net providers do not have adequate infrastructure for data, quality improvement, and analytics to compete in value-based payment programs. Frequently, there is insufficient risk adjustment for patient social risk factors that affect clinical performance metrics, making the playing field for safety-net providers uneven and exacerbating a preexisting, racist payment structure.^{45,46} Social risk adjustment for payment could make alternative payment models, such as accountable care organizations, more likely to enroll and care for marginalized communities.^{47,48}

Define and operationalize nonprofit hospital tax status to substantially benefit marginalized communities. The criteria for what qualifies as community benefit is broad and lax and varies by locality, but it can be operationalized with an antiracist lens.⁴⁹ Nonprofit hospitals differ greatly in the amount of **community benefit** and charity care they provide,⁵⁰ with some hospitals not meeting the charitable intent of the tax code.⁵¹ An antiracist lens would pay specific attention to how existing payment structures contribute to inadequate resources among safety-net providers and negatively affect marginalized populations.

Implement payment incentives to advance health equity. Payment incentives to produce equitable outcomes could help drive change.^{36,48,52} Fee-for-service payment, which incentivizes volume of services, not value or equity, is still prevalent. However, value-based payment programs and alternative payment models could reward disparities reduction and improvement in the care and outcomes of racially minoritized populations if they were intentionally designed to advance health equity.⁵² At the federal level, the CMMI is initiating innovations designed to improve care and outcomes of marginalized populations. For example, the ACO REACH (realizing equity, access, and community health) program will test accountable care organization (ACO) models that incorporate innovative payment approaches to improve care delivery in underserved communities and measurably reduce health disparities.⁵³ Moreover, the Centers for Medicare and Medicaid Services (CMS) Health Care Payment Learning and Action Network Health Equity Advisory Team published a technical guide providing recommendations on how care delivery redesign, payment incentives and structure, and performance

measurement can advance health equity.⁴⁸ CMS could enact financial withholds if health care organizations do not reduce gaps in care and outcomes. Plans and health care organizations could track and reward patient-centered measures that patients and communities find meaningful. Any incentive plan, however, should have measures to prevent gaming and include monitoring to identify and address negative, unintended consequences.

At the state level, the Oregon Medicaid program supports and incentivizes coordinated care organizations to address patients' social needs through an SDOH screening incentive metric, flexible funding for health-related services, required investment in SDOH and equity, increased community involvement in SDOH investment, and risk-adjusted global budgets with bonuses if performance metrics are met.⁵⁴ The Massachusetts Medicaid ACO program requires assessment of health-related social needs of the enrolled population, available community resources, and gaps in community services. It also provides incentives to address SDOH via encouraging organizations to partner with community-based organizations, offering flexible services, and adjusting payment for the social risk of beneficiaries.⁵⁵ Implementing antiracist policies requires ongoing review and understanding of structural and racist drivers of health care and outcomes.^{20,22,23,56}

Broader changes to the health care system that could further integrate currently segregated systems of care include universal health insurance, lowering the age of eligibility for Medicare, adequately funding Medicaid, and implementing all-payer total cost of care systems, such as in Maryland, which provide strong incentives for preventive and primary care for the populations served to reduce costly hospital admissions.⁵⁷

Conclusion

Being antiracist is more than not being racist. It requires ongoing commitment to advocating for and enacting racial equity. Identifying racism and integrating antiracism into an organization is every person's responsibility. It can be difficult to think about how to enact change, particularly within Byzantine institutional structures that make us feel like small guppies in a giant ocean. As theorist Audre Lorde once stated: "We operate in the teeth of a system for which racism and sexism are primary, established, and necessary props of profit."⁵⁸ Without reform, the medical payment system is in danger of permanently calcifying existing divisions in health care that unfairly disadvantage people of color with low incomes. Quality medical care should not be tied to one's race or paycheck.

Just because change is difficult, it doesn't mean we should opt for things to stay the same. All members of the medical community—from payers, to providers, to support staff—have a responsibility to reform our separate and unequal system. The question is not *if* but *how* racism manifests in the system. For a payment structure to do the most good for the most people, it must be reviewed regularly to stop problems, prevent them from beginning, and develop antiracist reforms that advance health equity. Antiracist payment reforms have great potential to desegregate health care systems and to ensure that everyone has a fair opportunity for optimal health.

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Why VIP Services Are Ethically Indefensible in Health Care

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Abstract

Many health care centers make so-called VIP services available to “very important persons” who have the ability to pay. This article discusses common services (eg, concierge primary care, boutique hotel-style hospital stays) offered to VIPs in health care centers and interrogates “trickle down” economic effects, including the exacerbation of inequity in access to health services and the maldistribution of resources in vulnerable communities. This article also illuminates how VIP care contributes to multitiered health service delivery streams that constitute de facto racial segregation and influence clinicians’ conceptions of what patients deserve from them in health care settings.

Insurance and Influence

It is common practice for health care centers to make “very important person” (VIP) services available to patients because of their status, wealth, or influence. Some delivery models justify the practice of VIP health care as a means to help offset the cost of less profitable sectors of care, which often involve patients who have low income, are uninsured, and are from historically marginalized communities.¹ In this article, we explore the justification of VIP health care as helping finance services for patients with low income and consider if this “trickle down” rationale is valid and whether it should be regarded as acceptable. We then discuss clinicians’ ethical responsibilities when taking part in this system of care.

We use the term *VIP health care* to refer to services that exceed those offered or available to a general patient population through typical health insurance. These services can include concierge primary care (also called boutique or retainer-based medicine) available to those who pay out of pocket, stays on exclusive hospital floors with luxury accommodations, or other premium-level health care services.¹ Take the example of a patient who receives treatment on the “VIP floor” of a hospital, where she receives a private room, chef-prepared food, and attending physician-only services. In the outpatient setting, the hallmarks of VIP service are short waiting times, prompt referrals, and round-the-clock staffing.

While this model of “paying for more” is well accepted in other industries, health care is a unique commodity, with different distributional consequences than markets for other goods (eg, accessing it can be a matter of life or death and it is deemed a human right under the Alma-Ata Declaration²). The existence of VIP health care creates several dilemmas: (1) the reinforcement of existing social inequities, particularly racism and classism, through unequal tiers of care; (2) the maldistribution of resources in a resource-limited setting; (3) the fallacy of financing care of the underserved with care of the overserved in a profit-motivated system.

Reinforcing the Social Divide

The very existence of VIP services allows for multiple tiers of care along racial and socioeconomic lines, thereby reinforcing patterns of racism and classism already present in the United States. Despite a decline in the overall number of uninsured nonelderly individuals across all racial and ethnic groups over the last decade, nonelderly Black, Hispanic, American Indian/Alaska Native, and Native Hawaiian/Other Pacific Islander individuals continue to be uninsured at higher rates than nonelderly White individuals.³ Even among those who have health insurance, significant racial divides exist among those who have private insurance and those who have Medicaid. The Kaiser Family Foundation estimated that, in 2019, 74% of White Americans had private health coverage and that 19% were enrolled in Medicaid, whereas 52% of Black Americans had private health coverage and 37% were enrolled in Medicaid.³

A danger in recreating these racist and classist hierarchies in care delivery is that doing so can lead practitioners and learners to internalize these values. Having health care delivery systems that practice VIP care sanctions the notion that wealthy patients’ lives and their bodies are worthy of a higher level of care even in the emergency room: a chest complaint from a VIP patient should be treated first, while other patients with the same complaint should wait in line longer or deserve less attention from specialty doctors. This example of certain patients waiting longer for emergency care goes against the intent of the Emergency Medical Treatment and Labor Act of 1986, a law enacted by Congress to ensure access to emergency treatment for all people regardless of ability to pay and a guiding principle of the practice of emergency medicine.⁴ Additionally, VIP classification and other signifiers of importance and wealth may implicitly affect clinical decision making and care delivery. As Shoa Clarke observes in a *New York Times* opinion article: “When I allow one of my patients to be labeled ‘important,’ do I implicitly label the others as less important?”⁵

For patients themselves, a multitiered system of care might also reinforce existing ideas of deservedness. Already, many people choose not to enroll in public programs, such as welfare, due to perceptions of being dependent on the “system” or due to shame that is reinforced when receiving social benefits.⁶ In one study of women who use drugs and their views on welfare, one participant reflected: “I wonder about welfare. It is supposed [to] help poor folks with a place to live, food, and insurance.... I understand that there are things we have to do to show that we deserve the money.... They get into personal things, like who do you sleep with or who do you share a toothbrush with.”⁷ As was famously stated by the US Supreme Court in *Brown v Board of Education* (1954), segregation “generates a feeling of inferiority.”⁸ This potential impact on patients cannot be ignored.

Distribution of Resources

In addition to reinforcing existing social inequities, VIP care disproportionately uses finite resources, as the increased resources allocated to the wealthy deplete the resources available to other patients. Given the shortage of primary care doctors in the United States,⁹ the influx of physicians to concierge practices effectively works to **decrease the number of physicians available** for the rest of the population. Moreover, compared to their counterparts, physicians in concierge primary care have a smaller patient load and serve fewer Black, Hispanic, or Medicaid patients.¹⁰ Thus, concierge medicine decreases access to primary care overall¹¹ and might disproportionately impact Black and Hispanic communities whose members are more likely to be uninsured or on Medicaid.

While it may seem that highly personalized health care provided via concierge primary care would result in better health outcomes, there are few studies supporting that it does so.^{12,13} Moreover, it poses the risk of overutilization or misutilization of resources.¹⁴ Thus, concierge primary care does not necessarily improve the health of those who pay membership fees while causing detriment to those who receive care under traditional health insurance programs.

An important ethical consideration for physicians considering a switch to concierge medicine is their duty to advance the health of communities and to care for the underserved, as this switch often involves keeping the wealthiest patients and leaving the poorer and often sicker patients to be cared for by other clinicians in the health system.¹⁵ The American College of Physicians (ACP) released a position paper on concierge primary care that highlights physicians' ethical and professional obligations to consider the disparate impact of these service models on patients with lower incomes as well as their ethical obligation to provide nondiscriminatory care.¹⁴ The ACP acknowledges the advantages of concierge care for primary care physicians (eg, less paperwork, higher compensation, and smaller patient panels), while also recognizing that its high cost to patients contributes to health care disparities. The ACP recommends that clinicians and practices that engage in concierge care consider "ways to mitigate any adverse impact on the poor and other underserved populations,"¹⁴ although it does not provide guidance on what that mitigation might entail.

VIP services in the inpatient setting have not been extensively studied. One study of hospitalist physicians' perceptions regarding VIP patients and services found that a majority (63%) of physicians felt pressured by VIP patients and families to order additional testing that they felt was medically unnecessary.¹⁶ This pressure to order **medically unnecessary testing** is at odds with Medicare and Medicaid regulations aimed at reducing wasteful use of resources.¹⁷ The same study showed that the majority (78%) of physicians did not perceive a difference in quality of care between VIP and non-VIP care, with 17% perceiving that VIP care was worse and 6% perceiving that VIP was superior.¹⁶ However, the actual health outcomes of these services have not been studied. Thus, similar to the outpatient setting, inpatient VIP care may lead to overutilization of medical resources, which, in a setting of finite resources, means less access to resources for non-VIP patients, without a clear benefit in quality of care. If VIP services were shown to improve health outcomes, then these services should instead become standard of care rather than an opt-in service for the wealthy.

Financial Implications

A fundamental defense of the practice of hospital-based VIP services is that it is a financial tool to enable the provision of care to patients with low incomes—a trickle down

approach to health economics. While there is scarce literature on revenue expenditures related to VIP services, studies suggest that high earners do not pay for health care for patients with low incomes. Researchers for the Kaiser Family Foundation estimate that uncompensated care costs for uninsured individuals averaged \$42.4 billion per year between 2015 and 2017 and that nearly 80% of uncompensated care costs were covered by government payments.¹⁸ They suggest that the remaining share was covered by a mix of private payers, such as philanthropic organizations and workers compensation, but do not mention whether any of these costs were supported by VIP services.¹⁸ The “cost shifting” argument made by health care systems—that charging more for privately insured patients or other high-earning payers compensates for low reimbursement rates for Medicaid—has 2 main flaws: it assumes that hospital costs are fixed and that low reimbursement rates for Medicaid result in hospitals charging privately insured patients higher prices.¹⁹ One study found that a reduction in Medicare payments led to a *decrease* in private payment rates—the opposite of what cost-shift theory would suggest.²⁰ This result is likely due to competition driving prices down for all payers and an individual hospital’s negotiating power in that health care market.¹⁹ While there might be individual cases of hospitals using VIP care to subsidize services for patients with low incomes, this business model is not common practice. On a macro level, greater profits do not correlate with greater levels of **uncompensated or “charity” care**. One study evaluating the provision of charity care at US nonprofit hospitals found that hospitals with higher net income provided disproportionately less charity care than those with lower net income.²¹

While cost shifting is a popular theory employed to defend the provision of VIP care, it does not hold up in practice. Like businesses in any other profit-driven industry, health care systems are motivated to maximize services that maximize their profits (eg, concierge care) while minimizing their losses. No regulation exists that forces a health care system to balance VIP services with uncompensated care, so these services are untethered. There is no financial reason why VIP care would serve to advance health equity, and there is no evidence that health care systems use the infusion of VIP dollars to fund care for patients with low incomes.

Conclusion

VIP health care, while potentially more profitable than traditional health care delivery, has not been shown to produce better health outcomes and may distribute resources away from patients with low incomes and patients of color. A system in which wealthy patients are perceived to be the financial engine for the care of patients with low incomes can fuel distorted ideas of who deserves care, who will provide care, and how expeditiously care will be provided. To allow VIP health care to exist condones the notion that some people—namely, wealthy White people—deserve more care sooner and that their well-being matters more. When health institutions allow VIP care to flourish, they go against the ideal of providing equitable care to all, a value often named in organizational mission statements.²² At a time when pervasive distrust in the medical system has fueled negative consequences for communities of color, it is our responsibility as practitioners to restore and build trust with the most vulnerable in our health care system. When evaluating how VIP care fits into our health care system, we should let health equity be a moral compass for creating a more ethical system.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

How Does Racial Segregation Taint Medical Pedagogy?

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Abstract

Persistence of racial segregation makes equitable health care impossible for African Americans, as does the supra-geographic segregation perpetuated by enduring racial medical mythologies that remain unchallenged in health professions education. This article canvasses how these mythologies exacerbate myopia in health professions practice and education, maintain barriers, and perpetuate racial health inequity.

Codifying Racial Segregation

In 1870, the American Medical Association (AMA) twice excluded¹ the racially integrated delegation from Washington, DC, to the AMA's national meetings while admitting a White one.² Between 1846 and 1910, the AMA developed a state-based organizational structure that excluded most African American physicians even as the association shaped medical education.² Schools commonly rejected Black medical aspirants like James McCune Smith, who moved to Glasgow, Scotland, where he earned his medical degree in 1837,³ and Daniel Laing, Isaac Snowden, and Martin Delaney, who were admitted to Harvard Medical School in 1850 but were expelled when White students protested.⁴

African American physicians responded by founding their own societies^{2,4,5} and medical schools because the relatively few Black patients admitted to White hospitals were typically pressed into service as “teaching material” and research subjects.⁶ When the AMA decided to elevate medical education by creating the Council on Medical Education in 1904, it did not essay to treat the 9 million underserved African Americans in the South.² Instead, the AMA Council commissioned the Carnegie Foundation for the Advancement of Teaching to evaluate American medical education and produce the 1910 **Flexner Report**, which recommended closing all but 2 of 7 African American medical schools—Howard and Meharry.⁷ Moreover, the report castigated African American physicians—already denigrated as purveyors of drugs, alcohol, and abortion^{8,9}—as “limited,” declaring: “A well-taught negro sanitarian will be immensely useful; an essentially untrained negro wearing an M.D. degree is dangerous.”⁷ Five of the 7 schools closed, and the number of African American physicians plummeted, ensuring that Black patients’ needs remained unmet. A lingering consequence today is that only 5% of US physicians are Black.¹⁰ And though African American men, who have

the nation's lowest life expectancy, fare best when cared for by Black men physicians,¹¹ Black men constituted just 2.9% of medical students in 2019.¹²

As the civil rights era dawned, African American physicians advocated for Medicare and Medicaid legislation that the AMA disparaged as “socialized medicine.”¹³ The AMA’s long-standing resistance to these programs included distributing pamphlets to members declaring that “Help should be given to those who need it but not to those who are able to take care of their own needs” and warning that such governmental insurance programs “would result in the overcrowding and overutilization of hospitals by those who could be better cared for at home.” Other AMA promotional materials asked: “Would socialized medicine lead to socialization of other phases of life?”¹⁴ As I have noted elsewhere, it was Medicare that “enforced hospital desegregation via the 1964 Title VI of the Civil Rights Act, but de facto segregation and bias lingered, even in the North.”¹⁵ De jure **segregation** ended without support of the AMA.²

Contemporary Segregation

As Nancy Krieger and colleagues have shown, segregation still dictates many African Americans’ health status.^{16,17} Black women born in segregated states are more likely than those born in nonsegregated states to have estrogen receptor-positive breast cancer,¹⁶ yet clinical education is largely silent on this and other significant health effects of discrimination.^{17,18} Moreover, utilization of racial genetics in medicine ignores its role as an extension of biological dimorphism promulgated by 19th-century scientists^{6,19} to support African American racial inferiority. In 2005, for example, isosorbide dinitrate/hydralazine was approved by the US Food and Drug Administration to treat congestive heart failure in African Americans only, based on a theory of racial genetic vulnerability.²⁰ The drug’s adoption continues centuries of medicine’s espousing biological dimorphism to support the claim that Black and White Americans suffer different diseases and require different treatments.^{6,21}

Despite habitually being treated as a biological category, race is a social construct, one that medical texts address in a profoundly illogical manner. Research papers, textbooks, and lectures treat racial groups as a significant patient descriptor even as they fail to define terms like *African American*, *Black*, *White*, and *Hispanic/Latinx*. Medical discourse may fail to address ethnicity in a nuanced way, as when Black and White categories are set in opposition to broad Hispanic labels that ignore the fact that Hispanics are members of an ethnic group whose composition varies widely and whose members can identify as multiracial.²² Moreover, texts and lectures can stress race as a social construct even as prominent and consistent use of race-based medicine sends a very different message to students, as it serves to reify race.²³

Medical education is relatively silent about clinical guidelines that deploy race to assess everything from treating urinary tract infections in infants²⁴ to the advisability of vaginal birth after caesarian section.²⁵ For example, the American Heart Association’s Get With the Guidelines–Heart Failure Risk Score predicts the risk of death in hospitalized patients but adds 3 unexplained additional points to any “nonblack” patient, thereby categorizing all Black patients as lower risk²⁶ (and therefore less likely to receive aggressive care²⁷). Similarly, equations used in estimating glomerular filtration rate (eGFR) add a point or more to the eGFR of Black patients, suggesting that Black patients have better kidney function.²⁶ Use of these tools results in denying procedures to African American patients.²⁶ Thus, **tailoring treatment to race** remains a powerful part of medical

education that in some instances prevents African Americans from receiving treatment, just as barring the doors of hospitals to Black patients once restricted their care.

Pedagogical Silence as Iatrogenic Harm

“The maxim is ‘*Qui tacet consentit....* Silence gives consent,’” wrote Robert Bolt in *A Man for All Seasons*.²⁸ Medical pedagogy’s silence—its failure to address persistent mythologies that threaten the health care of African Americans—gives stigmatizing beliefs credence and inflates health care disparities by barring access to treatment. A legion of beliefs—such as that African Americans’ bodies differed so dramatically from White people’s that they did not feel pain²⁹ and were immune to killers like heatstroke and yellow fever—supported enslavement^{30,31,32,33,34,35,36} and the yawning chasm between White and African American health profiles.^{6,37}

Today, the same mythologies persist to hobble the health care and health status of African Americans. For example, a 2016 study documented that more than half of all medical student respondents and most resident physicians still believe that African Americans do not feel pain as White patients do and that they have “thicker skin” and “stronger bones.”³⁸ These myths are not inscribed in medical textbooks, so it is likely that students are taught them on clinical floors as they frequently observe African Americans in pain being dismissed as drug seeking and sent away without analgesia. Such neglect is exacerbated by stigmatizing language in medical charts, which is 2.5 times as likely to be found in the records of Black patients as White ones.³⁹

Resurgence of both biologic dimorphism and blame-the-victim theories during the COVID-19 pandemic took the form of putative genetic differences.⁴⁰ The surgeon general’s invoking alleged behaviors—such as drug and alcohol use, obesity, and failure to practice social distancing⁴¹—to explain African Americans’ high rates of infection and death^{42,43} eclipsed discussions of documented risks to African Americans posed by environmental racism,⁴⁴ low rates of health insurance coverage, and a relative paucity of personal physicians.⁴³ At the same time, medical journals and news media decried African Americans’ shunning of COVID vaccine trials while invoking the imaginary primary or even solitary role of the 1932-1972 US Public Health Service Study at Tuskegee (in which the US Public Health Service withheld standard-of-care antibiotic treatment from hundreds of Black men in Alabama who had been diagnosed with syphilis) in buttressing a purportedly widespread African American aversion to research and vaccination.^{45,46,47,48} Actually, 4 centuries of medical abuse, not overreaction to a single study, has fomented some African Americans’ resistance to a variety of research and treatment initiatives.^{49,50} However, the frequent claim that African Americans shunned the COVID trials en masse is fictitious.⁵¹ The real culprits that prevented nonelderly people of color from receiving vaccines were health policy decisions, such as prioritizing the elderly and health care and high-status workers⁵² but not the essential workers earning low wages who often shared their risks.

Conclusion

Racial segregation, both de jure and de facto, has powerfully separated African Americans from equitable health care. But so does the extra-geographic segregation perpetuated by persistent racial medical mythologies. To achieve more equitable care without racial bias, medical curricula should actively correct errors not only in texts but also in clinical teaching and modeling. Correcting the history of medicine canon to identify disparate treatment, abuse, and erroneous beliefs is an important step that has already begun in texts such as *Fatal Invention: How Science, Politics, and Big Business*

Re-create Race in the Twenty-first Century,⁵³ *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*,⁶ and *Medicine and Slavery: The Diseases and Health Care of Blacks in Antebellum Virginia*³⁴ and within inclusive curricula.⁵⁴ Expanding this education will equip students to interrogate racial bias in patient care and policies.

The COVID-19 pandemic has thrown the overreliance on biological dimorphism and the prevalence of blame-the-victim theories into sharp relief. Clinicians must eschew these and allied clinical stances, such as the belief in disparate pain sensitivity and the reliance on racial algorithms. But correcting these stances and beliefs should extend to frank indictments of them for the benefit of students and healers in training.

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ART OF MEDICINE

A Clinical Encounter in Historical Context

Julia O'Brien

Abstract

This drawing considers the importance of understanding history's role in contextualizing many patients' present-day health care experiences.

Figure. *Bandage and Bondage*



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Perhaps the patient in this drawing recognizes her own place in a historical narrative. A well-intentioned nurse might have no idea about how constriction for blood pressure measurement could trigger **transgenerational fear** in an African American patient whose pulse beats in her arm like a drum, taking her back 200 years when Africans in bondage were medically abused.

James Marion Sims (1813-1883) is credited with being the “Father of American Gynecology,”¹ although his victims—Anarcha, Betsey, Lucy, and more—have been largely

unacknowledged.² At right, this drawing echoes *J. Marion Sims: Gynecologic Surgeon*, a 1952 painting by Robert Thom,³ reminding viewers about forgotten “Mothers of Gynecology.”⁴ Sims is also credited with inventing the modern-day speculum,¹ which has not been significantly improved since the 1840s,⁵ as many women today can attest. Although racially diversifying practitioners won’t solve **structural inequity** alone,⁶ a historically conscious clinician might empathize with patients of color.

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ART OF MEDICINE

"What Race Are You?"

Julia O'Brien

Abstract

This comic shares a true story of a physician's fraught interaction with and examination of a patient and prompts consideration of how context, empathy, and emotional intelligence play key roles in how well patient-physician conversation is likely to go in the moment and when replayed by a patient after an awkward, uncomfortable encounter.

Figure. "What Race Are You?"



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Sometimes a story can be captured in a single image, and this is one such story. So, when a patient seems phenotypically multiracial, we might consider that, clinically and ethically, there's no reason to **ask about race** when that patient is in pain and when the clinician's head and hands are between a patient's legs.

Physicians aren't always between our legs, but they can get incredibly personal when gathering information, so *when* they ask a question and *what* they ask are important to how comfortable a patient might feel when responding. Questions about one's relationship or marital status, sexuality, sex-assigned at birth, age, or employment don't seem necessary from a patient's perspective and can feel intrusive, interrogative, and like superfluous fodder for unwelcome judgment about matters that aren't clinically relevant at the moment.

For me, this situation was odd because I identify as mixed-race, so I'm accustomed to people constantly asking about my heritage. But, for some reason, I was caught off-guard when the question, "What race are you?," emanated from beneath the drape and filled the room. My first thought was "I'm Fuchsia," which informed me that I immediately felt weird and nervous. My legs were open, naked, and I couldn't see the physician's face. I answered with honesty before even questioning why my racial identity would matter, especially right now.

Patients don't have to be in extremely **vulnerable physical positions** for a clinician to hold power over their body and safety. Small talk can be helpful in distracting patients from their anxiety and can give well-intentioned, emotionally intelligent clinicians an opportunity to establish their interest, sincerity, competence, and trustworthiness. But a poorly timed question, ill-informed comment, or unnecessary joke is a source of risk that can make an already stressful trip to urgent care even more stressful.

Over the following few days, I wondered whether I should have declined to answer or simply lied. This self-doubt exacerbated the pain of having to replay the whole uncomfortable scenario in my head again. If I had said I was white, would I have gone home with an appropriate, helpful intervention instead of continuing to suffer whatever condition I had that this physician did not properly diagnose? Although clinicians' personal questions can be relevant to collaboratively resolving a health problem, some questions express bias and social prejudice that can make the clinical encounter itself a source of iatrogenic harm.

If physicians aren't aware of their capacity to do this kind of harm when they're between your legs, what else might they miss?

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LETTER TO THE EDITOR

Response to “What Should Clinicians and Patients Know About the Clinical Gaze, Disability, and Iatrogenic Harm When Making Decisions?” Novel Reasons for Diversification of Health Care

Vishruth M. Nagam

As Chloë Atkins and Sunit Das write in “[What Should Clinicians and Patients Know About the Clinical Gaze, Disability, and Iatrogenic Harm When Making Decisions?](#),” medical care provided for patients with disabilities is imbricated with the “medical gaze,” a lens of presumed objectivity of medical knowledge and clinicians and of the depersonalization of evidence-based medicine—both of which are normative and potentially stigmatizing and fail to consider the experience of disability embodied by patients. Consequently, patients with disabilities might feel their sense of autonomy, self-determination, and control over their care diminished by how values such as beneficence, nonmaleficence, and justice are endorsed by clinicians in practice.

Atkins and Das suggest the inclusion of critical disability ethics and ableism studies in clinical education, which might help to foster more culturally and ethically sensitive care by health care professionals.^{1,2,3,4} Nevertheless, unsaid is that patients with disabilities sometimes may not agree with, trust, or feel comfortable with care from clinicians without disabilities.⁵ In a patient-centered approach, responsibility for directly integrating the embodied experiences of disability in clinical care can be enacted by many and especially by health care professionals with disabilities. [Patient satisfaction](#) and compliance result when life experiences of clinicians closely match those of patients.⁶ Additionally, health care professionals with disabilities may contribute to colleagues’ [learning experiences](#) of disability, thereby increasing the sensitivity of colleagues without disabilities.⁵

Thus, [diversification](#) of student bodies in health professions schools and [increasing numbers of health care professionals with disabilities](#) might improve care and outcomes of patients with disabilities. Although over a quarter of US adults live with a disability, studies suggest a disability prevalence of 3.1% and 4.6% among physicians and medical students, respectively.^{7,8,9} While the proportion of clinicians with disabilities is projected to increase, disparity and inequity in representation of disability in the US health care workforce still exists.¹⁰ Contributing factors include misperceptions of medical school or residency program applicants with disabilities as less “fit” or competent, which controverts long-standing recognition that health care professionals with disabilities make key contributions to the health professions.⁹

Meeting the medical needs of a population requires discernment and warrants accurate representation of members of the population in the workforce that provides the care to that population.¹⁰

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