HEALTH JUSTICE: ADDRESSING MODERN DAY HEALTH CARE SEGREGATION

Ruqaiijah Yearby, JD, MPH
Kara J Trott Professor in Health Law, The Ohio State University
Co-Founder, Collaborative for Anti-Racism & Equity

By all that I hold highest, I promise my patients competence, integrity, candor, personal commitment to their best interest, compassion, and absolute discretion, and confidentiality within the law.

I shall do by my patients as I would be done by; shall obtain consultation whenever I or they desire; shall include them to the extent they wish in all important decisions; and shall minimize suffering whenever a cure cannot be obtained, understanding that a dignified death is an important goal in everyone's life.

I shall try to establish a friendly relationship with my patients and shall accept each one in a nonjudgmental manner, appreciating the validity and worth of different value systems and according to each person a full measure of human dignity.

I shall charge only for my professional services and shall not profit financially in any other way as a result of the advice and care I render my patients.

I shall provide advice and encouragement for my patients in their efforts to sustain their own health.

I shall work with my profession to improve the quality of medical care and to improve the public health, but I shall not let any lesser public or professional consideration interfere with my primary commitment to provide the best and most appropriate care available to each of my patients.

To the extent that I live by these precepts, I shall be a worthy physician.

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PHYSICIAN OATH VERSUS THE BUSINESS OF MEDICINE

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Death From a Toothache: The Story of Deamonte Driver and Where We Stand Today in Ensuring Access to Dental Health Care for Children in the District

ROADMAP

- Health Care Segregation
  - ✔ Hospital Segregation
  - ✔ Hospital Closures
  - ✔ Patient Segregation
  - ✔ Unequal Care

- Health Justice Framework
  - ✔ Truth and Reconciliation
  - ✔ Community-Driven Change
  - ✔ Financial Supports and Accommodations

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Hospital Segregation

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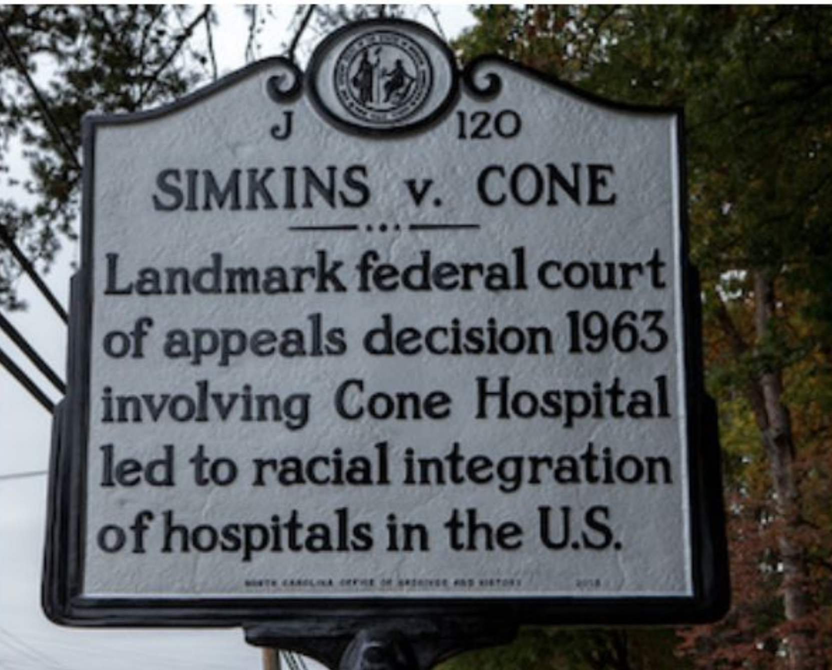
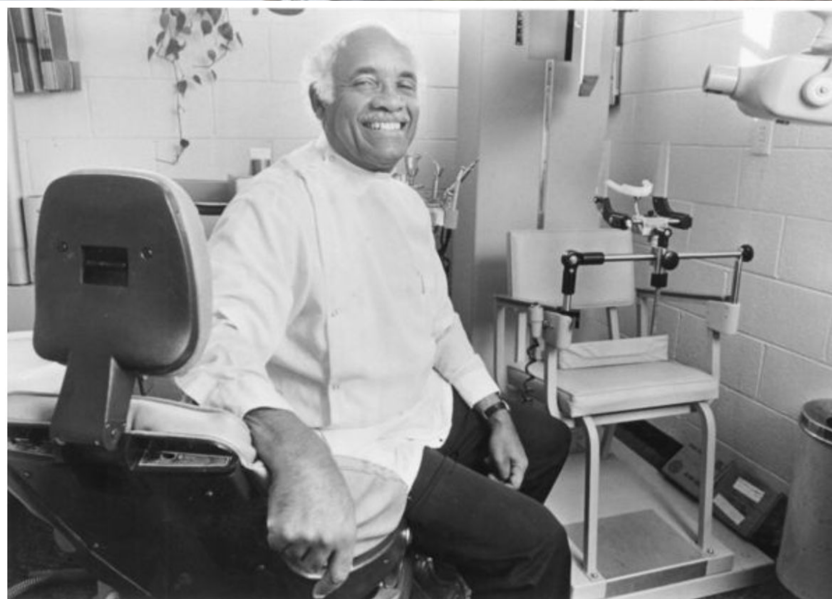
Section 622(f) of the Hill-Burton Act stated:

[S]uch hospital or addition to a hospital will be made available to all persons. . . but **an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group. . .**

Hill-Burton Act of 1946, Hospital Survey and Construction Act, 42 U.S.C. § 291e(f)





Dr. George Simkins, Jr. Source: Greensboro Medical Society.

Simpkins v Moses H. Cone Memorial Hospital

- Black dentists, physicians, and patients filed a lawsuit against three hospitals in North Carolina for race discrimination as state actors based on their receipt of Hill-Burton funding
- U.S. Attorney General Robert Kennedy intervened on behalf of the Black dentists, physicians, and patients
- U.S. Court of Appeals for the Fourth Circuit ruled that Section 622(f) of the Hill-Burton Act was unconstitutional

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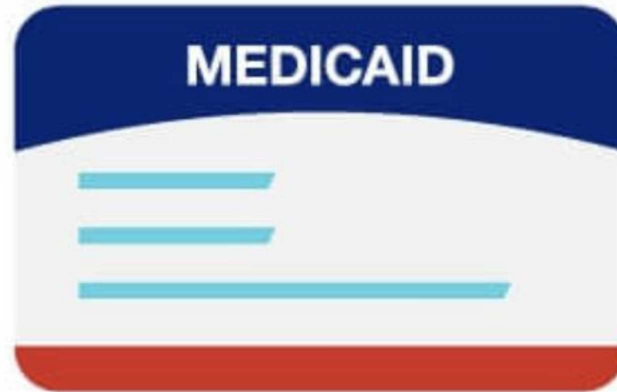
Legal Guarantees of Equal Treatment

Title VI, Civil Rights Act of 1964

No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

Medicaid



For individuals, families, and children with limited income & resources

Medicare

Generally for people who are 65 & older, or who have a qualifying disability

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HOSPITAL SEGREGATION (CONT.)

3 King/Drew Deaths Blamed on Lapses

Three questionable deaths at King/Drew followed months of assurances that employees had been rigorously retrained and new policies put in place to prevent breakdowns in care. (Robert Gauthier / LAT)

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HOSPITAL CLOSURES

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- A higher proportion of racial and ethnic minority individuals in the area around hospitals has been significantly associated with urban hospital closures during the periods of 1950-60, 1960-70, and 1970-80 (Sager, 1983)

- Between the 1950s and 1970s, hospitals across the country were racially integrating and as a result many of the hospitals located in predominately Black neighborhoods were closed

- This trend has continued even after hospital systems' initial efforts to racially integrate hospitals

HOSPITAL CLOSURE (CONT.)

- ❖ Research shows hospital systems often close hospitals in racial and ethnic minority neighborhoods and relocate hospitals to suburban sites in predominately White neighborhoods (Rice, 1987)

- ❖ There are three patterns:
  - ✔ Maintenance of the city facility and construction of a suburban satellite hospital that duplicate services offered at the city facility, [leading to the closure] of a major portion of the city facility;
  - ✔ Closing a *major portion* of the city site and construction of a new, full services suburban facility;
  - ✔ Closing of *the entire* city facility and construction of a new, full services suburban hospital. (Rice, 1987)

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HOSPITAL CLOSURES (CONT.)

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HOSPITAL CLOSURES (CONT.)

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SAINT LOUIS: SEGREGATION & CLOSURE

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SAINT LOUIS: SEGREGATION & CLOSURE (CONT.)

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"**You have the formal structure and then you have the informal structure. Even today every attempt is made in semi-private rooms to put two Blacks in semi-private rooms and two whites in the semi-private room.** Where do you go? They will deny it. There is supposed to be an open admissions policy and if you have semi-private insurance and you go into a hospital whatever bed is available they are supposed to put you in there with whatever patient is in there. On a selective basis the admissions office are the ones that control that, but they are only doing what the administration tells them to do. Somehow they have a marking system so that they can tell that in 6000B that the patient there is "B," or maybe they put a little star next to it. If you just walk through the building there and just look into those rooms from time to time, see how many mixed occupants they have in some of the rooms. If you notice predominantly the semi-private rooms have two Blacks in them nine out of 10 times. As long as they have the option, and this is not the luck of the draw."

Paul N. Saunders, Oral History Washington University St. Louis, July 6, 1990

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PATIENT SEGREGATION

Provider Care Team Segregation and Operative Mortality Following Coronary Artery Bypass Grafting

John M. Hollingsworth, MD, MSc*; Xianshi Yu, PhD*; Phyllis L. Yan, MA; Hyesun Yoo, PhD; Dana A. Telem, MD, MPH; Ekow N. Yankah, JD, BCL; Ji Zhu, PhD; Akbar K. Waljee, MD, MSc†; Brahmajee K. Nallamothu, MD, MPH†

CONCLUSIONS: There are often unique systems of provider care teams, which treat Black patients but do not overlap with those of White patients undergoing coronary artery bypass grafting. Provider care team differences may contribute to surgical outcome variability between Black and White patients.

PATIENT SEGREGATION (CONT.)

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Factors Related to Physician Clinical Decision-Making for African-American and Hispanic Patients: a Qualitative Meta-Synthesis

Khadijah Breathett[1] · Jacqueline Jones[2] · Hillary D. Lum[3] · Dawn Koonkongsatian[2] · Christine D. Jones[4] · Urvi Sanghvi[2] · Lilian Hoffecker[5] · Marylyn McEwen[6] · Stacie L. Daugherty[7] · Irene V. Blair[8] · Elizabeth Calhoun[9] · Esther de Groot[10] · Nancy K. Sweitzer[1] · Pamela N. Peterson[7,11]

One Caucasian physician shared how she had not sent her racial/ethnic minority patients to see specialists when indicated because the patients were underinsured.

> So it's really hard to get a lot of specialists. And they will be upset if you refer someone that really doesn't need to be referred to see medical assistance patients. Because they're not going to get reimbursed for it at all. And they don't want to be seeing something that the primary care provider could have taken care of. Whereas…someone who's educated, working, has good insurance, they want…probably specialist because their insurance is going to pay for it. So that's a disparity. (female, Caucasian) (3p393).

Another Caucasian physician described that racial/ethnic minority patients were less adherent to medical regimens. Therefore, she was less likely to send her patients to specialists.

> …if a physician feels the patient isn't very compliant with the regimen they've recommended, then they might be less likely to send them to a specialist…if they're not even following up with the treatment I recommend, why bother to send them to another physician, who's going to recommend, to evaluate this problem when they're not even taking care of their hypertension in the first place? (female, Caucasian) (3p390).

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UNEQUAL TREATMENT

A Caucasian physician described an example of bias or racism towards African-American patients leading to differences in clinical care.

> I've had ... [Black] patients who I think have not been offered procedures because of either where they were economically or where they were assumed to be economically because of their race... I had a patient who clearly needed to be catheterized for their presentation and it was suggested that we do medical management. And I remember talking to the cardiologist and just saying that I didn't understand why we're doing this ... As soon as we started talking, he said, 'oh well, of course, we'll cath him.' And so, like that, it changed...[I] certainly have enough anecdotal experience to think that people are probably [being] treated differently based on race. (male, Caucasian) (11p5).

(Breathett, et al., 2018)

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The New York Times

Health

I Am a Racially Profiling Doctor

By Sally Satel
Published: May 05, 2002

In practicing medicine, I am not colorblind. I always take note of my patient's race. So do many of my colleagues. We do it because certain diseases and treatment responses cluster by ethnicity. Recognizing these patterns can help us diagnose disease more efficiently and prescribe medications more effectively. When it comes to practicing medicine, stereotyping often works.

Perspective: **Are We Teaching Racial Profiling? The Dangers of Subjective Determinations of Race and Ethnicity in Case Presentations**

Kimberly D. Acquaviva, PhD, MSW, and Matthew Mintz, MD

Abstract

Physicians make subjective visual assessments concerning the race and/or ethnicity of their patients and document these assessments in patient histories every day. Medical students learn this practice through textbooks and the example set by their educators. Although physicians may believe that they are helping their patients, the practice of using visual clues concerning race and/or ethnicity to determine whether a patient is at risk of certain diseases lacks scientific rigor and may put the patient at significant risk of receiving substandard medical care. The authors argue that if the patient's race or ethnicity is of critical importance, the data should be collected through more objective, scientifically rigorous means, such as genetic testing. In this article, the authors call for the widespread transformation of the way medical schools teach tomorrow's physicians about the role of race and ethnicity in taking medical histories, and they challenge physicians to change their current practices.

Acad Med. 2010; 85:702–705.

UNEQUAL TREATMENT (CONT.)

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UNEQUAL TREATMENT (CONT.)

(Hoffman, et al., 2016)

Table 1.

Percentage of white participants endorsing beliefs about biological differences between blacks and whites

Item	Study 1: Online sample (n = 92)	Study 2			
		First years (n = 63)	Second years (n = 72)	Third years (n = 59)	Residents (n = 28)
Blacks age more slowly than whites	23	21	28	12	14
Blacks' nerve endings are less sensitive than whites'	20	8	14	0	4
Black people's blood coagulates more quickly than whites'	39	29	17	3	4
Whites have larger brains than blacks	12	2	1	0	0
Whites are less susceptible to heart disease than blacks*	43	63	83	66	50
Blacks are less likely to contract spinal cord diseases*	42	46	67	56	57
Whites have a better sense of hearing compared with blacks	10	3	7	0	0
Blacks' skin is thicker than whites'	58	40	42	22	25
Blacks have denser, stronger bones than whites*	39	25	78	41	29
Blacks have a more sensitive sense of smell than whites	20	10	18	3	7
Whites have a more efficient respiratory system than blacks	16	8	3	2	4
Black couples are significantly more fertile than white couples	17	10	15	2	7

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UNEQUAL TREATMENT (CONT.)

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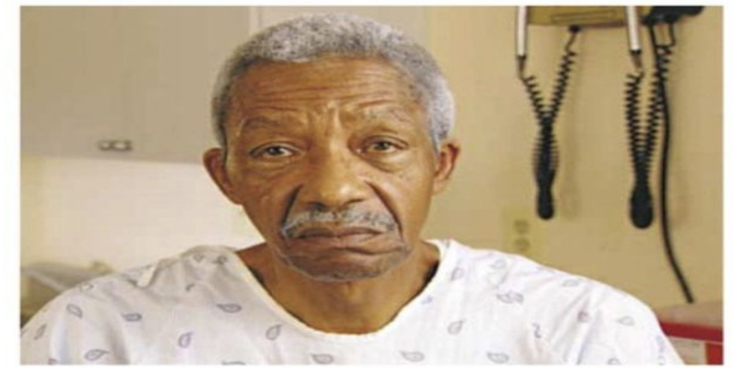
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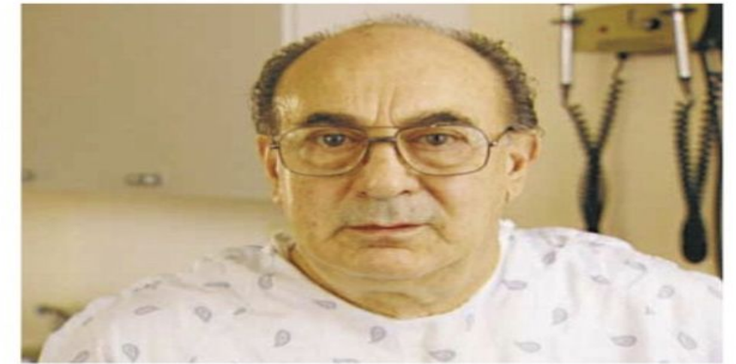
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1999 NEJM Article on Physician Racial, Gender Bias Stirs Controversy

The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization

Kevin A. Schulman, M.D., Jesse A. Berlin, Sc.D., William Harless, Ph.D., Jon F. Kerner, Ph.D., Shyrl Sistrunk, M.D., Bernard J. Gersh, M.B., Ch.B., D.Phil., Ross Dubé, Christopher K. Taleghani, M.D., Jennifer E. Burke, M.A., M.S., Sankey Williams, M.D., John M. Eisenberg, M.D., William Ayers, M.D., et al.

Article Figures/Media

40 References 1310 Citing Articles Letters

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DOI: 10.1056/NEJM199902253400806

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UNEQUAL TREATMENT (CONT.)

Race-Based Prescribing for Black People with High Blood Pressure Shows No Benefit

Study Finds Established Guidelines May Limit Black Patients From Receiving the Full Range of Appropriate Medications for Hypertension

By Linda Apeles

Generations of physicians have been taught that Black people with high blood pressure should be treated with a narrower range of medication options than all other racial groups. This race-based approach to prescribing has no apparent patient benefit, according to a UC San Francisco study.

The guidance could also be limiting access to medications that could achieve better overall health outcomes in Black patients, say the authors of the study published Jan. 13, 2022, in the *Journal of the American Board of Family Medicine*.

(Holt, et al, 2022)

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UNEQUAL TREATMENT (CONT.)

In the same health system, Black patients are prescribed fewer opioids than white patients

White patients received both more pills and stronger doses, according to the study, published Wednesday in the New England Journal of Medicine. In about 90% of the 310 health systems studied, the opioid dose prescribed to white patients was higher than the one prescribed to Black patients. On average, white patients received 36% more pain medication by dosage than Black patients, even though both groups received prescriptions at similar rates.

By studying disparities at the system level, you are "getting closer to the underlying phenomena," said Salimah Meghani, a pain management disparities researcher at the University of Pennsylvania School of Nursing who was not involved with the study.

The researchers found that differences in opioid dosages existed even when patients were being seen by the same clinicians.

"[Black patients] get fewer pills, lower dose, lower potency — they just are getting less," said Morden.

Black patients were also more likely to receive short-term opioid prescriptions, for less than a year's time, than receive long-term ones. The disparities even held true for a population of cancer patients, who are usually treated long-term with opioids for their severe pain.

(Morden et al., 2021)

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MODERN-DAY HEALTH CARE SEGREGATION

- Hospitals that serve racial and ethnic minority patients are often understaffed and underfunded
- Hospital closures are associated with the racial makeup of the neighborhood
- Racial segregation of patients persists within hospitals
- Racial and ethnic minority individuals are often denied equal access to medically necessary care
- These practices harm racial and ethnic minority individuals

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HEALTH JUSTICE FRAMEWORK

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- Legal and policy responses must include a **truth and reconciliation process** that acknowledges the existence of racial segregation and provides a mechanism to overcome trauma (Yearby, 2023)
- **Impacted communities**, particularly racial & ethnic minority communities, must **drive/lead** the creation, implementation, and evaluation of interventions (Benfer, Mohapatra, Wiley & Yearby, 2020)
- **Financial supports and accommodations** must be provided to offset the harm (Benfer, Mohapatra, Wiley & Yearby, 2020)

HEALTH JUSTICE: TRUTH AND RECONCILIATION

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- The healthcare system has tried to address medical malpractice by having providers apologize for their mistakes, building on the restorative justice movement, "as a way for an offender to accept responsibility for hurting a victim," which did not deserve the harm (Curtis, 2010)

- **Implicit Bias training & Diversity, Equity and Inclusion efforts MUST be tied to legal requirements of equality** AND **include measurable goals** for eliminating unequal treatment

HEALTH JUSTICE: COMMUNITY-DRIVEN CHANGE

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- Impacted communities, particularly racial and ethnic minority groups, must drive/lead the creation, implementation, and evaluation of interventions to address racial segregation in health care
- **Make community health workers, who are often from impacted communities, a part of the health care team if approved by the community**
- Adopt community-driven programs to eliminate implicit bias, which includes real time tracking of care provided to patients

HEALTH JUSTICE: FINANCIAL SUPPORTS AND ACCOMMODATIONS

- ❖ Student-run free clinics provide holistic care
  - ✔ Free clinics should be run by professors
- ❖ Increasing language access at free clinics
  - ✔ Increase language access at all facilities
- ❖ Anti-racism curriculum updates and integrations
  - ✔ Offerings should be mandatory for medical students and clinicians

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HEALTH JUSTICE: FINANCIAL SUPPORTS AND ACCOMMODATIONS (CONT.)

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- ❖ Health care systems and hospitals need to provide financial supports and accommodations for those harmed by hospital segregation, which should include:
  - ✔ Concierge care
  - ✔ Access to academic medical centers
  - ✔ Assistance with applying for Medicaid, instead of sending the bills to collections

ADDITIONAL READINGS

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