

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

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

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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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Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

Citation

AMA J Ethics. 2023;25(1):E7-14.

DOI

10.1001/amajethics.2023.7.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

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