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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?

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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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Editor's Note

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