Towards a More Healthy America:

Reallocation of Health Care Resources In An Inequitable Health Care System

Carole Guy, M.D., F.C.C.P.

Pulmonary, Critical Care And Sleep Medicine; Sleep Disorder Centers of Delaware

The COVID-19 pandemic and the video recorded murder of George Floyd have brought long overdue national mainstream focus and discussion to the persistent inequities in our American health and healthcare system. It is my belief and hope that these horrific events will serve as a catalyst for more rapid solutions.

A brief historical journey may help us find solutions towards the creation of a more equitable healthcare system. Since the institution of slavery in 1619, our country has experienced over 400 years of systemic racism. The institution of slavery was later replaced by harsh systems of share-cropping and convict leasing and by Black Codes and Jim Crow laws well into the late 19th and early 20th century. The legacies of such systems continue to this day – affecting all aspects of life, including healthcare.

During slavery, the United States healthcare system was in its infancy. In 1848, a survey by the American Medical Association (AMA) found that 23% of practicing physicians in Virginia were practicing medicine without either an apprenticeship or medical school education.[1] Those enslaved suffered from cholera, pneumonia, dysentery and dietary deficiencies. In order to avoid the expenses of physicians for enslaved persons, those maintaining slavery, including masters and overseers, often provided the "care" for sick or ailing enslaved persons themselves. Equally troubling, Virginia medical schools used Black persons, enslaved and free, for both clinical and anatomical medical studies more often than Whites.[1] Scholars have determined that medical experimentation on enslaved persons and freed Blacks was often done without anesthesia and used to develop certain medical techniques and professionalize medicine.[1]

After the American Civil War (1861-1865) and the Emancipation Proclamation (1863), Black American citizens were held back from obtaining their constitutional rights promised under three new constitutional amendments (the 13th, 14th, and 15th Amendments) by Black Codes and Jim Crow laws. The Black Codes, sometimes called Black Laws, were instituted to limit the rights and freedoms of both free and recently freed Black persons, and to compel them to work for low wages. Such laws existed in both northern and southern states before and after the Civil War – denying Black persons the right to vote, to attend public schools, and to equal treatment under the law. For example, in 1865, Mississippi had a Black Code or law that required Black workers to have written evidence of employment for the coming year. If they left before the end of the employment contract, they would be forced to forfeit earlier wages and they were subject to arrest.[2] As is true today, with low or no wages it is difficult, if not impossible, to obtain sufficient, consistent or quality healthcare.

Following the Reconstruction Era (1863-1877), during which period gains were made by African-Americans, the Black Codes were expanded by Jim Crow Laws - state and local laws that enforced racial segregation in southern states. Such laws were upheld by the U.S. Supreme Court in *Plessy v. Ferguson* and remained in effect until the mid to late 1960's. Thus, our American Constitution failed to secure the blessings of liberty to all her citizens.

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As late as 1942, Kentucky's laws required separate but "equal" accommodations for nursing homes for African-Americans.[3] Such accommodations and healthcare were rarely if ever "equal" during this period. Facilities for African-Americans were consistently inferior and underfunded; and sometimes, there were no facilities at all.

Although such laws were not adopted by northern states, discrimination in healthcare, housing, and education existed there as well.

W.E.B. DuBois wrote in 1906, "The high infant mortality in Philadelphia today is not a Negro affair but an index of social condition."[4] DuBois advocated for improved sanitary conditions, education, and better economic opportunities to improve the health of Blacks. American hospitals denied Blacks admission or treated them in segregated wards in attics and damp basements. Due to segregation and discrimination, Black doctors and health professionals found it necessary to establish separate hospitals and professional organizations such as the National Medical Association (NMA), which was formed in 1895. In 1917 in the Journal of the National Medical Association, Black physicians wrote about health disparities created from socioeconomic inequalities not physiologic or biologic differences or inferiority.[4]

Such laws and practices created both unequal access to healthcare and segregated healthcare facilities which laid the foundation for present health and healthcare system inequities.

In 1965, President Johnson signed into law legislation that created the Medicare and Medicaid Programs.[5] The formation of Medicare proved to be a tipping point for our then-segregated healthcare system, because it forced the rapid desegregation of American hospitals. Hospitals that practiced racial discrimination could have their now necessary Medicare federal funds withheld under Title VI of the Civil Rights Act of 1964.

Delaware, like the rest of the United States, has a long history of segregation in its healthcare system. The history of tuberculosis treatment of African Americans in Delaware provides a lens from which to view this segregated system. The Delaware Anti-Tuberculosis Society and the Tuberculosis Commission worked to build the first TB sanatorium in the United States dedicated exclusively to the treatment of Black patients. The Edgewood Sanatorium was built with funds from the Delaware State legislature and the Delaware Anti-Tuberculosis Society and opened in 1915.[6] Dr. Conwell Banton, an African American physician who graduated from the University of Pennsylvania School of Medicine in 1900 and was licensed to practice in Delaware, served as the medical director for many years.[7] The sanatorium was expanded in 1939. Tuberculosis disproportionally infected and affected Blacks then and now. In 1951 African Americans accounted for 24% of all cases of TB in Delaware despite making up only 14% of the Delaware population at the time.[6] In 2018, the CDC reported an eight times higher case rate of TB amongst African Americans compared to Whites.[8] I, an African American female physician, had the privilege of providing clinical care to tuberculosis patients at the Delaware Department of Public Health clinics during the late 1990s until 2001. I was able to provide care to Black, Latino, White and Asian patients in a desegregated health care system, unlike Dr. Banton who served his patients tirelessly in a segregated sanatorium. While we have made progress towards our goal of eliminating health inequities, there is much work to be done and a more accelerated progression is necessary.

Prior to completing medical school in 1988 and practicing in a desegregated healthcare system, my personal history is that I was born 13 days before the March on Washington in 1963 in a segregated Philadelphia hospital, Mercy Douglass. The Frederick Douglass Memorial Hospital and Training School was founded in 1895 by African American physician, Dr. Nathan F. Mossell, to

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care for the sick, to afford hospital opportunities for Black physicians and to train Black nurses. After merging with Mercy Hospital in 1948, it closed in 1973.

Founded on a systemically racist system, though our healthcare system is now desegregated it remains inequitable, and the COVID-19 pandemic has magnified these inequities. Blacks and Latinos are suffering disproportionately and we have not been spared that reality in Delaware. As of August 17, 2020, the case rate of COVID-19 in Delaware was 474/10,000 among Latino/Hispanics, 205/10,000 among Blacks and 87.6/10,000 among Whites.[9] Health care providers can no longer be silent or neutral about inequities in health and healthcare. Some have recognized this and are speaking out.

We knew about these inequities prior to COVID-19 and solutions are necessary. There is evidence that African Americans have a higher incidence of conditions requiring Intensive Care Unit (ICU) level care compared to Whites after adjustment for differences in poverty and region.[10] African Americans also have higher age adjusted rates of both in and outpatient cardiac arrest, acute lung injury, noncardiogenic acute respiratory failure, and venous thromboembolism.[10]

We can no longer ignore what we know. The healthcare community must find solutions. Increased access to health insurance and medical care to improve chronic pre-existing conditions is necessary. Black and Brown patients must receive medical care early when they develop a critical illness. Differential access to post-acute care, including post-acute COVID-19 care, must be eliminated.

Public health advocates, practitioners, activists, legislators and other policy makers must also fight together to improve education, decrease poverty, and increase healthcare literacy. Each is an important variable to health outcomes. Broken public school systems contribute to inequity in health and healthcare by decreasing the pipeline of physicians to our communities and decreasing the ability of minority patients to fully advocate on behalf of themselves and their family members in health care contexts. America in general – and Delaware specifically – must fix our schools and create successful pipelines to increase the number of Black and Brown physicians and healthcare providers. Blacks make up 13% of the U.S. population and 21% of the Delaware population, but only make up 7% of U.S. medical students and 5% of active U.S. physicians.[11] Delaware mimics this inequity with non-Hispanic Blacks making up only 6.6% of the primary care physicians in Delaware.[12]

African American physicians and health care providers must feel welcome and supported in Delaware. Feeling "alone" in medicine may be felt by Black physicians. Despite having board certifications, medical degrees and clinical expertise, Black medical students, residents and attending physicians may find themselves continuously having to "prove" themselves to colleagues. Dr. Banton advocated for Black tuberculosis patients in the early 1900s; more than 100 years later, Black physicians continue to tirelessly advocate for Black and Brown patients too often "alone." Minority students have been found to be more likely to report that race/ethnicity negatively impacted their medical school experience and have cited "racial discrimination, racial prejudice, feelings of isolation and different cultural expectations."[13]

The legacy of my father graduating from Temple University School of Medicine in 1961 certainly assisted me in becoming a physician, and likely contributed to my decision to specialize in Pulmonary, Critical Care and Sleep Medicine. However, after graduating almost three decades

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later from the same medical school as my father, his legacy could not shield me from the entrenched racism of America's medical schools and healthcare system. I'll never forget my excitement of starting my first clinical exposure. It was sullied by a White clinical instructor who informed me unprovoked that, "It did not matter" how smart I was or that I had received all Honors and High Passes in my first two years of medical school, but that this was "different now" and that he was now in charge of the grading during my clinic course.

The NMA is the largest and oldest national organization representing African American physicians and their patients in the United States. It is the collective voice of African American physicians, and the leading force for parity and justice in medicine and for the elimination of disparities in health. The local Delaware First State Chapter of the NMA was an active voice in the fight to ensure Black and Brown Delawareans were counted during the COVID-19 pandemic. By providing a community of physicians with shared experiences, the NMA helps Black physicians to not feel "alone," and to assist in the advancement of social justice in medicine.

The formation of the NMA in 1895 was in response to the exclusion of African-American physicians from the AMA (American Medical Association) and local state medical societies. In 1968, the AMA voted against motions prohibiting racial discrimination by member/local medical societies despite "condemning racial discrimination," thereby sending the implicit message that such discrimination was permissible. In 2008, the AMA issued a formal apology to the NMA and African American physicians for one and a half centuries of systemic and overt racism towards African American physicians, their families and patients. In 2020, I am optimistic but vigilant.

The COVID-19 pandemic has exposed the inequitable allocation of health care resources and resultant disparities in the health of Blacks and Latinos/Hispanics. During the regional peak of the COVID- 19 pandemic in Delaware, I wrote an opinion piece entitled, "Delaware Needs Statewide Ethics Board To Oversee Allocation of Ventilators, COVID-19 Supplies."[14] At the time, my concern was that a possible surge in hospital admissions could make ventilators a scarce resource that would require attention to the necessity of fair and just allocation. I recommended creation of a statewide ethics board for pandemic COVID-19 with representation from our Delaware community, including young and old, Black, Brown, White and Asian individuals. Subsequently, on the Journal of the American Medical Association (JAMA) published a systematic review, "Variation in Ventilator Allocation Guidelines by US States during Coronavirus Disease 2019 Pandemic."[15] Only 26 states provided guidance on how this allocation should occur. Guidelines varied significantly and it was concluded that there could be inequity in allocation of mechanical ventilator support during a public health emergency such as the COVID-19 pandemic.[15] I remain concerned that this statewide inequity could again mimic the racial inequities in our health care system in the US.

As a State, a refocus on social justice work was spurred by the storm of the COVID-19 pandemic and the murder of George Floyd, as demonstrated by the passage of Delaware Senate Bill 191.[16] SB 191 is a Delaware Constitutional amendment to protect against discrimination on the basis of race, color and national origin with protections that parallel those provided in the National Civil Rights Act of 1964. After the passage of SB 191, the legislative Black Caucus of Delaware announced their "Justice for All Agenda" in June, which includes establishment of an African American Task Force "entrusted with exploring the disparities experienced by people of color throughout Delaware and proposing remedies to address those inequities."[17] It is our duty as health care providers to not only care for our patients at their bedsides, but to improve their health through advocacy and education of our legislators to ensure that racial inequities in health

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and healthcare systems are eliminated. A similar effort was seen in Michigan when Governor Whitmer created the Coronavirus Task Force on Racial Disparities to ensure all Michiganders have equal access to critical health care resources; we can do the same in Delaware.

Fortunately, Delaware never required ventilator allocation. But we may require COVID-19 vaccine allocation, and we should ensure this allocation is just and equitable. Additionally, our entire health and healthcare system, at the State and national level, requires just and equitable allocation of resources. I believe we are up for the task. We have the resources, the skill sets, and our efforts are now refocused due to the intersecting impact of COVID-19 and the civil discourse related to the "Black Lives Matter" movement.

When I graduated from medical school three decades ago, I took a modified Hippocratic Oath. One current version is "as a member of the medical profession I WILL NOT PERMIT considerations of age, disease, disability, creed, ethnic origin, gender, nationality, political affiliation, RACE, sexual orientation, social standing or any other factor to intervene between my duty and my patient" [emphasis mine]. We know "We can't breathe" and we need to fix this.

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