RACISM IN MEDICINE: PLANNING FOR THE FUTURE

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African Americans and other minority populations have not benefited to the same degree as the majority of Americans from the advances in health care in our country. The vestiges of racism have resulted in inequities which exist in training, medical practice, medical decision making, the work environment and biomedical research. Recommendations are made to eliminate racial and ethnic bias in healthcare through monitoring and increasing the number and the distribution of medical trainees proportionate to the diversity of the U.S. population; through improvements in the medical school curriculum to include the impact of race and ethnicity on healthcare outcomes as well as the effect of physicians' attitudes on health; through the inclusion of an adequate number, mix and distribution of health care professionals relative to the diversity of the participants in health plans with due process for patients and physicians; and through increased participation in peer review research funding, training and as subjects in biomedical research directed to improve the quality of healthcare for diverse populations. (*J Natl Med Assoc.* 2001;93:1S–5S).

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The National Medical Association (NMA) has been fighting to improve health care for African Americans, other minorities, the poor and underserved for over a century. In that quest, the NMA has promoted increased training of African-American physicians, the desegregation of hospitals and universities, increasing African-American patient involvement in biomedical research and ensuring ethical treatment and protection of study subjects as well as promoting access to quality health care for all Americans–particularly African Americans, the poor and underserved. However, racial biases and stereotypes continue to permeate medical training, the medical school curriculum, medical practice and biomedical research. As we enter a new century, it is critical to review the impact that racial bias has on health care and plan for the future.

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WORKPLACE

Despite our collective best efforts to train an adequate number of physicians to treat underserved African-American communities, we have fallen short and, more importantly, are losing ground. Only 3.6% of all practicing physicians in America are African American, representing only a slight increase over the past decade.[1] Although data indicate that African-American physicians are five times more likely to treat black patients than their white counterparts and are four times more likely to treat poor and underserved patients, there is no concrete plan under way to address the inequities in the distribution of health care resources or educational opportunities.[2,3]

IMPACT OF ANTI-AFFIRMATIVE ACTION INITIATIVES

Currently, African-American college matriculation is declining. In 1996, enrollment dropped to 8.1%,[4] and African-American enrollment in medical school declined 8% between 1994 to 1998.[5] After years of increasing the training opportunities, we now face a concerted effort to reduce funding for special programs designed to expose young students to math, science and health careers, as well as to eliminate scholarships based on race in several states. Consequently, applications for admission to medical school in the states with anti-racial and gender preference legislation have declined significantly: 19% reduction in minority applicants in California and a 22% in Texas, Louisiana and Mississippi between 1994 and 1998.[6]

Since the passage of Initiative 200 anti-affirmative action legislation in Washington State, African-American matriculants decreased by 40%. Hispanic and Native American matriculants decreased 20% and 30%, respectively, at the University of Washington.[7] This is a critical time to reassess our needs and strategically plan to increase resources and opportunities to train physicians who are committed to practicing in our communities.

MEDICAL PRACTICE

The current declining trend in the enrollment of African-American medical students will add further stress to a system with low numbers of African-American and other under-represented minority specialists and primary care physicians. These physicians traditionally treat this nation's underserved poor and minority communities of America. Instead of reducing the necessary resources and opportunities that enable prospective minority medical students to choose a career in medicine, a critical analysis is needed of the best practices for admission criteria. For example, a commitment to treating poor and underserved populations, an attitude that engenders patient trust, cultural sensitivity and understanding of the language and health habits of the community, as well as other factors should be considered by admissions committees.

Even as postgraduate trainees, African-Americans are subjected to intimidation and threats. Some are dismissed without a clear explanation, on grounds that are at best subjective. Second, there is no grievance procedure and few options short of litigation. Clearly, a needs assessment, strategy and business plan with goals to eliminate inequities in medical education by 2010 is critical.

BIAS AND MEDICAL DECISION MAKING

The unequal health care treatment for blacks continues to plague a society that prefers to focus on the possible economic advantages that accompany professional training rather than the poor health care outcomes that have plagued blacks since slavery. The lagging support for the medical education of African Americans comes at a time when controlled, peer-reviewed studies demonstrate racial biases and stereotypes influence medical decision making. Lack of physician exposure to race and racial issues in medical school curriculum are indicative of suboptimal care for underserved patient populations.[8] Health care provider attitudes may have been modeled from the textbooks which have often depicted blacks stereotypically. The recent Schulman et al study published in the *New England Journal of Medicine* demonstrated medical bias when white physicians referred black patients and women for medically necessary cardiac work-up and treatment 60% as often as white males.[8] It is no wonder that cardiac mortality for African Americans is 40% to 50% higher than that for their white counterparts.[9]

As with white patients, African Americans rated their encounters as more participatory when physicians and patients were of the same race. However, data suggest that in the current health care delivery system, African-American patients rate their physician/patient encounters as less participatory than white patients.[9] Many African Americans want access and choice of black physicians, as demonstrated in a recent market research study[10] and in a survey performed by the New America Wellness Group with Morehouse School of Medicine.[11]

WORKFORCE ISSUES

Our efforts, however, must extend beyond medical education to the practice of medicine. Although black physicians have historically cared for the nation's sickest and poorest patients, the current system of health care is not serving African-American physicians or patients well. Daily, black doctors encounter insurmountable barriers as member physicians on insurer and managed care panels and networks. Because their practices are more likely to be established in communities with disproportionate numbers of low-income and severely ill patients, African-American physicians have been excluded from networks and panels because the cost of treating these patients is not cost-effective for the insurer. In fact, physicians have been profiled by the

insurance industry based on resources expended per patient, which, for black physicians, results in racial profiling due to the increased resources required to treat black patients due to the severity of their illness. There are two dire consequences to such racial profiling: physician exclusion from plans with little notice or explanation and placing the economic burden for payment of medical care on patients who already have limited financial resources. In many instances, the sickest patients are shifted out of the plan, which may bode well for the plan's bottom line but not the patient's health.

The exclusion and de-selection of black doctors from health panels has critical implications for the access to and delivery of health care services to African Americans and the underserved. For example, all black board-certified orthopaedic surgeons in Cincinnati, Ohio were excluded by the major health plan. In this city where 38% of residents are African American, clearly a diverse health care work force of culturally competent, diverse and accessible physicians is needed. Only after great protest, however, were the excluded doctors reinstated as participants in the health plan.

Another tactic used to exclude African-American physicians from participation in health plans is lack of board certification, which is generally a requirement for plan providers. Prior to 1970, many board certification exams were subjective and African Americans were deliberately failed. As a result, many older African-American physicians are not board certified. Other criteria, apart from board certification, must be used to evaluate the quality and competency of African-American physicians.

Historically, African-American physicians were denied hospital staff privileges because of race. Prior to the civil rights movement of the 1960s, African Americans were denied access to equal facilities by whites, and wards, floors and even hospitals were segregated. Frequently, peer-review boards, often without input from outside experts, would restrict or suspend African-American physicians privileges. Often, the only recourse for the physician has been litigation, an exhausting process both financially and spiritually. Today, however, actual and potential discrimination of African-American physicians by managed care organizations includes restrictive selection of service areas, contracting with only certain physicians, failure to offer a choice to the patient and restrictive network formatting. Many of these practices continue unchecked and plans have adopted a take-it-or-leave-it attitude; and the situation is not helped by the lack of grievance procedures or due process for physicians.

BIOMEDICAL RESEARCH

African Americans have also not participated in clinical research in adequate numbers for a host of reasons,[13, 14] but research is crucial to identifying the best therapies for diseases primarily affecting blacks. It is also true that any effective pharmaceutical treatment is dependent on taking into account metabolic factors affecting availability of the drug and side effects from treatment. However, metabolism and response to adverse reactions, which are influenced by environment, culture, and genetic factors, vary in different racial, ethnic and gender groups.[15] Differences in health care outcomes are so significant in African Americans and other under-represented minorities that a Presidential initiative to eliminate racial and ethnic disparities in health care outcomes is currently underway.[16]

A striking illustration of the significance in metabolic differences is current data showing that serum levels of cotinine, a nicotine metabolite, are substantially higher in African Americans than in white or Mexican-American smokers who smoked the same number of cigarettes per day.[17] This has significant implications as to the potential for increased exposure to carcinogens, higher rates of lung cancer, and greater difficulty in smoking cessation that black smokers face compared with whites as well as the need for improved treatment strategies.

Additionally, more clinical trials are needed to understand the effect of ethnicity on pharmacokinetics. For example, African Americans treated for mental illness are frequently misdiagnosed and given improper medication and doses, resulting in increased side effects and noncompliance.[18]

The low participation of African Americans in biomedical research studies can be attributed to:

- concerns about medical experimentation,
- distrust of the research/medical establishment,
- toxic effects of treatment,[19]
- failure by researchers and institutions to actively recruit African Americans,
- few minority clinical investigators involved in or heading research projects,
- poor access to primary medical care,
- alienation of minority health professionals,
- lack of knowledge about clinical trials, and
- language and cultural barriers.[13]

Even the research used to make medical decisions about the health care of African Americans has rarely

included a critical mass of patients necessary to make statistically significant statements about the effectiveness of treatment. Another critical point is the failure to train and recruit African-American researchers and include African Americans in the decision making process when determining research priorities and funding.[13] These are important issues to ponder as we enter a new millennium.

As we re-invest ourselves to provide continuing quality improvement, eliminate health care disparities based on race and ethnicity and promote the health of America, the focus should be a critical analysis of the state of health care as it relates to the effects of racism. By strategically addressing necessary programmatic and system changes and investing in needed resources, parity in health care education and delivery can be achieved.

RECOMMENDATIONS

Workforce

The National Medical Association recommends support for programs that lead to:

- Increased numbers of African-American students in pipeline programs for entry into medical schools; more African-American medical students, postgraduate trainees in all specialties, African-American medical school faculty as well as more African-American practicing physicians proportionate to the diversity of the U.S. population. Data on progress in workforce improvement should be monitored annually by the President of the United States, the U.S. Congress, and the Association of American Medical Colleges (AAMC).
- Active opposition to anti-affirmative action ballot initiatives in collaboration with other organizations to highlight their negative impact on the medical education of African Americans and other minorities.

Medical School Curricula

The National Medical Association recommends that:

- All U.S. medical school curricula incorporate a course on the healthcare of racial and ethnic minorities.
- Every medical school design a course which helps students to identify their own intrinsic racial and ethnic biases and sensitizes them to the negative effects of such biases on the health outcomes. Such a course would:
  - Provide an understanding of how issues of racial attitudes.
  - Show how African Americans have not been helpless victims in the face of oppression but have developed strategies and institutions to care for themselves.
  - Provide a forum for students to talk about racism.

Medical Practice

The National Medical Association recommends that:

- Health plans establish and maintain adequate arrangements with a sufficient number, mix, and distribution of health care professionals and providers to assure that covered items and services are available and accessible to each enrollee under the plan in the service area of the organization; that health plans be located in a variety of sites of service, and have reasonable promptness--including reasonable hours of operation and after-hours services; and reasonable proximity to the residences and workplaces of enrollees; and in a manner that takes into account the diverse needs of enrollees; and reasonably assures continuity of care.
- Health plans serving medically underserved areas be required to contract with a sufficient number, mix, and distribution of health care professionals and providers who have a history of serving such areas.
- A grant program be established to provide outreach to inform individuals in medically underserved areas how to access managed care organizations in their communities and assist physicians and other health care professionals who serve in medically underserved areas in enrolling in managed care organizations.
- Medical decision making be determined by a licensed physician, in collaboration with patients.
- Physicians have the ability to collectively negotiate with health insurers and managed care organizations regarding all issues affecting quality health care and physician contracts.
- Physicians and patients have an internal and external review process for decisions made by health care entities, peer-review committees and organizations that includes a grievance and appeals mechanism for medical policy, medical necessity, and medical practice.
- Patients' rights to include:

* A ban on gag rules and practices in all health plans;
* Accountability by plans for negligent medical decision-making;
* Access to emergency room services;
* Guaranteed access to needed health care specialists; and
* Clear explanation of plan benefits prior to enrollment.
* U.S. Congress commission a study on racial bias in medicine.

Biomedical Research

The National Medical Association recommends that:

- National Institutes of Health, pharmaceutical industry, and the Food and Drug Administration elevate the status of research performed to focus on diseases and outcomes of care in minority populations and increase cultivation of senior African-American biomedical research scientists.
- Peer-review research conducted by African Americans be funded commensurate to levels of studies headed by nonblack investigators.
- Office of Research on Minority Health of NIH be elevated to a Center with the authority to set research priorities for areas that disproportionately affect minorities and fund peer review research.
- NMA offer a course to teach NMA physician members the skills needed to perform clinical research and that the NMA participate in a collaborative effort to advise African Americans on issues related to clinical studies; and
- NMA collaborate to provide information to the public on clinical research.

NOTE ADDED IN PROOF

In 2000, Congress passed legislation, S. 1880, "Minority Health and Health Disparities Research and Education Act," which was signed into law by President Clinton in November 2000. The legislation, which was vigorously endorsed by the NMA, elevated the status of the Office of Research on Minority Health to that of a center in the NIH. Additionally in 2000, Congress allocated funds for the Institute of Medicine to conduct a study on racial bias in medicine, which is scheduled to be completed in early 2002.

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