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RACESCIENCE

An Antiracist Agenda for Medicine

Colorblind solutions have failed to achieve racial equity in health care. We need both federal reparations and real institutional accountability.

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We are experienced physicians. But in the early days of the pandemic, when we felt like fresh interns nervously awaiting a flood of disease presentations we had never seen before, we had a nagging sense of déjà vu: it seemed that a disproportionate number of COVID-19 patients admitted to our Boston hospital were people of color. We asked around; our colleagues corroborated. The trend was confirmed by data coming out of Milwaukee first, then

sporadically elsewhere. Now it is a well-known and tragic fact of the pandemic.

Our effort to understand and correct racial health disparities has led us to rethink the nature of the fight for racial justice in medicine.

The experience was doubly jarring, however, because we had noted an analogous pattern in hospital admissions six years ago. In 2015 some of us wondered why Black and Latinx patients with heart failure—our hospital's most common diagnosis—seemed more likely than white patients to end up on our general medicine service rather than on our cardiology service, where patients have better outcomes (along with a more comfortable experience, including private rooms and better amenities). Our effort to understand and correct this disparity has led us to rethink the nature of the fight for racial justice in medicine.

After analyzing ten years of hospital data, we concluded that the trend we observed was painfully robust: white patients at Brigham and Women's Hospital—a prominent, predominantly white Harvard teaching hospital—were indeed more likely to be admitted to the cardiology service. We also found that the discrepancy, like many other racial health inequities, wasn't fully accounted for by insurance status, established links to care, other medical conditions, or an index reflecting the socioeconomic status of a patient's neighborhood. In a follow-up study we found that patient self-advocacy may play a role in these disparities: white patients were perceived to advocate for cardiology admission more often and more intensely, and providers acknowledged such behavior impacted their decision making.

Alarmed by these findings, we sought an immediate solution. As we began to advocate for change within our institution, however, we encountered significant resistance to calling this discrepancy an instance of institutional racism and to making race-explicit interventions—even at a time when the documentation of racial health inequities is accelerating. In medicine, as in other domains, the default options for addressing racial inequality are often limited: implicit bias training, diversity and inclusion efforts, the adoption of supposedly objective checklist-style clinical criteria for decision making.

These policies may help to mitigate some health inequities—increasing racial and ethnic diversity of health care providers is essential, given the evidence that Black patients with Black providers have better outcomes in many contexts—but history has convinced us that these options are not sufficient. Implicit bias training and checklists offer indirect solutions where more direct forms of race-explicit action are available; the objectivity aspired to in clinical criteria is also inevitably tainted by the pervasiveness of structural racism. What we need instead, we have come to believe, is a proactively antiracist agenda for medicine.

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Our path to this realization, as with nearly all advancements in social medicine, took us outside our discipline—through the field of critical race theory (CRT), in particular. This body of scholarship emerged thirty years ago when a group of legal scholars challenged the conventional wisdom that colorblind civil rights efforts could effectively dismantle structural racism. "The general use of so-called neutral standards to continue exclusionary practices," Harvard law professor Derrick Bell argued in 1992, "reduces the effectiveness of traditional civil rights laws, while rendering discriminatory actions more oppressive than ever." After more than five decades of colorblind law, the phenomenon Bell described has only worsened, and the stubborn persistence of racial inequities—both in health care and across society at large—gives the lie to the effectiveness of colorblind policies. Yet such solutions remain the go-to response, restricting the range of tools at our disposal for making desperately needed change and even inviting charges by prominent physicians that speaking of racism is counterproductive.

Recognizing this problem, public health scholars Chandra Ford and Collins Airhihenbuwa brought CRT's legal approach to the public health realm in 2010 with their landmark proposal of a Public Health Critical Race

Framework. Following their lead, we have sought to implement that framework in our own advocacy and clinical work on equitable heart failure admissions. Together with a coalition of fellow practitioners and hospital leaders, we have developed what we hope will be a replicable pilot program for direct redress of many racial health care inequities—one that takes seriously the limitations of colorblind solutions and empowers institutions in variety of contexts to take decisive action to achieve racial equity.

Building on calls for reparations, we call this a vision for *medical restitution*. Federally paid reparations—urgent and long overdue—would help to mitigate racial health inequities (including those seen in COVID-19), but they would not, on their own, end institutional and structural racism. We believe we must pursue restitution programs at the institutional level while also advocating for federal reparations.

Our case for medical restitution extends calls for reparations for Black Americans, which have a long history in the United States. (As the historian Robin D. G. Kelley notes in his 2002 book *Freedom Dreams*, they stretch back well before the Civil War.) Their visibility has grown in recent years, with much momentum building on Ta-Nehisi Coates's influential 2014 *Atlantic* essay "The Case for Reparations," and they are reaching a new pitch in the wake of COVID-19 and renewed protests over police brutality against Black Americans. (A recent House Judiciary Committee hearing on H.R. 40, a bill to create a commission to study reparations, is another positive sign.) Few have done more to develop the case than Duke University economist William Darity, Jr., whose recent book with A. Kirsten Mullen, *From Here to Equality: Reparations for Black Americans in the Twenty-First Century*, advances a vision of reparations as "a program of acknowledgment, redress, and closure for a grievous injustice."

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What effect would reparations have on systemic inequities in the health care system? Two prominent public health scholars, Mary T. Bassett and Sandro Galea, explored this question in the *New England Journal of Medicine* in November, identifying three "pathways" through which federally paid reparations for Black Americans might mitigate health disparities. One is the immediate expansion of limited financial resources, which would increase the ability "to obtain health-producing resources such as better neighborhoods, better schools, and access to cleaner air." The second is via reductions in stress within affected communities, an increasingly recognized contributor to poor health. And the third is via intergenerational effects. "Health is produced over the life course and across generations," the authors write, "and any effort in the present to level the wealth playing field could reset the potential wealth and assets—and consequent health—of future generations."

These are compelling arguments, and there is even more that might be said on the first point. Ability to pay determines much of one's access to health care in the United States, and inequities in uninsurance and insurance type are driven in large part by employment status, where institutional racism has long disadvantaged Black Americans. Unequal access to care also continues to be shaped by persistent housing inequality and racial segregation in both urban and rural areas, the result of historical policies such as redlining, blockbusting, and contract buying—which in turn only further entrenched wealth inequality. By reducing the racial wealth gap, federal reparations would help to mitigate all of these problems.

But in order to comprehensively confront structural racism, we think there are at least two reasons that federal reparations must be supplemented by localized antiracist institutional efforts of the kind we propose below.

First, many existing racial health inequities persist even after controlling for socioeconomic factors. Our own heart failure study illustrates how factors such as patient self-advocacy and provider bias shape racial discrepancies in health care outcomes. (For another stark example, consider the numerous stories of white elites presenting for COVID-19 vaccinations in impoverished neighborhoods of color.) Other racial health inequities unlikely to be

alleviated by federal reparations, at least in the short term, include the failure of hospitals and academic medical centers to hire faculty and staff that reflect patients' racial diversity, the undertreatment of Black patients' pain, longer wait times for patients of color, poor research funding for diseases like sickle cell that impact relatively few white people, and a lack of appropriate care or lower quality care for Black patients—even when being seen at the same facility, by the same providers, for the same condition, and with the same health insurance as white patients.

Structural and institutional racism thus lead to health inequities beyond the immediate reach of financial restitution but within the purview of medical institutions. While it is possible that the complex effects of federal reparations could, over time, help to mitigate these mechanisms of inequitable care, they are unlikely to do so in the short term. In the meantime, institutions must be held accountable.

Antiracist institutional change is essential to supplement federal reparations. If we are serious about achieving equity—both now and after federal reparations are paid—we must also pursue institutional action.

Second, trust between patients and providers is a prerequisite for equitable care, but federal reparations are unlikely to have a direct effect on the trustworthiness of medical personnel. This is especially true at predominantly white institutions, where Black patients have long acknowledged being harmed and made to feel unwelcome.

This erosion of trust in the medical system has a number of explanations, but most salient, along with the systematic denial of equal institutional access and care, is the long legacy of medical injustice perpetrated against communities of color. Many studies have analyzed the various forms of racism engrained in U.S. medical practice and research, from historic examples down to the present day. All of these help to explain why a Black or Indigenous patient or community may be hesitant to seek out medical care or to welcome the advice and treatment plans of health professionals.

Rather than being understood as a historically warranted adaptive response "towards eluding depredation," however, patient mistrust has often been framed as a brute driver of racial health inequities. In some accounts mistrust is portrayed not as a vital survival instinct but as the fault of communities behaving irrationally, or as a symptom that can be treated—through such policies as education campaigns or voucher programs—without addressing the underlying cause: institutional racism. As pediatrician and community health advocate Rhea W. Boyd and colleagues have written regarding the academic fallout the Tuskegee Syphilis Experiment, "decades of research have evaded the profitability of suffering to instead belabor patient trust as a cause of health disparities." Rather than ask what response to past harm might make our institutions worthy of trust, the effect is to lay the blame on marginalized communities and to distract from the underlying source of mistrust. The reality is that sustainable impacts on trust will only emerge from institutional reckoning with racism as the true etiology of racial health inequities.

For both of these reasons, we believe antiracist institutional change is essential to supplement federal reparations. If we are serious about achieving equity—both now and after federal reparations are paid—we must also pursue institutional action. Crucial to this work is a pragmatic orientation to what philosopher Naomi Zack calls "applicative justice"—"applying justice to those who don't now receive it"—as opposed to more idealistic conceptions of justice, whether derived from John Rawls or John Locke, on which some arguments for reparations are based.

This is exactly what we have tried to achieve in the design our new pilot initiative at Brigham and Women's Hospital set to launch later this spring. Adapting Darity's reparations framework of *acknowledgment, redress,* and *closure* (ARC) to an institutional level, we have designed a program—we call it a Healing ARC—with initiatives for all three components. Each centers Black and Latinx patients and community members: those most impacted by unjust heart failure management and under whose direction appropriate restitution can begin to take shape.

Acknowledgment

As Darity explains it, acknowledgment "involves recognition and admission of the wrong by the perpetrators or beneficiaries of the injustice." In our case, we take acknowledgment to entail informing patients about our heart failure findings at our hospital, claiming responsibility, and incorporating community ideas for redress. To this end, we are assembling focus groups from five priority communities, the neighborhoods with some of the highest populations of Black and Latinx residents in the city of Boston, to explain our findings, listen to responses and suggestions, and offer a space to discuss a just path forward. These focus groups will ensure that community oversight is an integral component of the program. We are also recruiting heart failure patients, who are intimately familiar with the hospital's admission process and the intricacies of inpatient and outpatient care, to participate as co-collaborators. Providers will acknowledge our heart failure inequities at relevant points of entry into care, ensuring patients are aware of this history and what is being done to address it.

Redress

Redress is simultaneously the most substantial and the most unprecedented component of our Healing ARC. In general, institutional redress should involve not just a direct solution to monitor and end health inequities but to offer restitution for past and present injustices. Redress could take multiple forms, from cash transfers and discounted or free care to taxes on nonprofit hospitals that exclude patients of color and race-explicit protocol changes (such as preferentially admitting patients historically denied access to certain forms of medical care).

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The case for redress is particularly urgent for academic medical centers such as our hospital. Because they receive enormous amounts of public funding through federal grants, non-profit tax-exempt status, and Medicare and Medicaid payments, among others, legal scholars have convincingly argued they have a special legal obligation to ensure equitable outcomes under Title VI of the Civil Rights Act of 1964. Even as academic medical centers increasingly attempt to bring their rhetoric and "antiracist" declarations in line with that of racial justice activists, their business plans pivot away from the material reckoning that is necessary to address racial health inequities. Shawn Johnson and Ayotomiwa Ojo offer a sharp analysis that zeroes in on some of the racist business practices of academic medical centers that Bell would surely recognize as "so-called neutral standards to continue exclusionary practices." Through aggressive profit-seeking, these institutions prioritize high-profit margin and privately insured patients, contributing to the de facto segregation that lands 50 percent of elderly Black patients in just 5 percent of all hospitals. In 2008 a Bronx coalition filed a civil rights complaint against three academic medical centers in New York as a result of this medical apartheid, although no remedial action resulted, and the problem persists largely unchallenged.

Sensitive to these injustices, we have taken redress in our particular initiative to mean providing precisely what was denied for at least a decade: a preferential admission option for Black and Latinx heart failure patients to our specialty cardiology service. The Healing ARC will include a flag in our electronic medical record and admissions system suggesting that providers admit Black and Latinx heart failure patients to cardiology, rather than rely on provider discretion or patient self-advocacy to determine whether they should go to cardiology or general medicine. We will be analyzing the approach closely for the first year to see how well it works in generating equitable admissions. If it does, there will be good reason to continue the practice as a proven implementation measure to achieve equity.

Offering preferential care based on race or ethnicity may elicit legal challenges from our system of colorblind law. But given the ample current evidence that our health, judicial, and other systems already unfairly preference people who are white, we believe—following the ethical framework of Zack and others—that our approach is *corrective* and therefore mandated. We encourage other institutions to proceed confidently on behalf

of equity and racial justice, with backing provided by recent White House executive orders.

Closure

To complete the Healing ARC with *closure*, community and patient stakeholders and institutional representatives must agree that the institutional debt has been paid and that a new system is in place to ensure that the problem will not reemerge. The point at which restitution is adequate for the debt incurred will be determined in conversation with community groups. But ensuring the inequity does not recur will require regular data monitoring and community updates. We believe this transparency is essential to establish institutional trustworthiness.

It is now common knowledge that disease and death from COVID-19 have disproportionately harmed Black, Indigenous, and Latinx communities in the United States. Though this trend became clear early on, no meaningful policies were enacted to mitigate it. A national testing strategy was scrapped, along with a campaign to send masks. And as the *Washington Post* reported in July, Trump advisors only began pushing the president to act when the virus began to impact "our people." What emerges from this tragic story is more than the gross incompetence decried by the editors of the *New England Journal of Medicine*. It is a story of incremental genocide, one that sits shamefully if inconspicuously within a centuries-long legacy of structural, scientific, and medical racism.

The outstanding debt from the harm caused by our institutions, and owed to our BIPOC patients, is long overdue: now is the time to start settling it.

Our treatment plan follows from this diagnosis. Federally paid reparations are essential, and broad adoption of Healing ARCs can build on them—directly

implementing restitution across a variety of institutional contexts and for a range of marginalized BIPOC communities. Through our pilot initiative, we hope to provide a replicable, CRT-informed framework that can move us beyond the historic cycle of documenting racial inequities while endlessly deferring their resolution. The outstanding debt from the harm caused by our institutions, and owed to our BIPOC patients, is long overdue: now is the time to start settling it.

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