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Dismantling Structural Racism in the Academic Residency Clinic

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On July 14, 1970, approximately 150 members of the Young Lords executed the first of a series of occupations of Lincoln Hospital, an academic health center in the Bronx. Disenchanted with the care provided at Lincoln and its outpatient residency clinics,[1,2] the group demanded, among other changes, that the hospital cut its ties with academia; they believed that high turnover of physicians and inconsistency in care stemmed from this relationship. For these political activists, the relationship's failure was unassailable: it was imprinted on the Black and Brown corpses in the local morgue and on a hospital that, one of its doctors noted, "looked more like an abandoned factory than a center for the healing arts." No more competing interests, the Young Lords declared, as they collaborated with like-minded resident physicians to create the first-ever patient's bill of rights, including the right "to choose the doctor you want to have and to have the same doctor treat you all the time."

Inspired by the Black Panther Party, the Young Lords were Puerto Rican and Black activists, originally based in Chicago and New York, who "sought to address issues of racism, incarceration and police brutality, employment, and inequality in education and public health, including sanitation, lead poisoning, access to decent health services, and hunger in the lives of poor children"[1] — issues that today would be called "structural racism." In January 1970, an article outlined the rationale for the hospital occupation that would occur 6 months later and demonstrated an early awareness of the structural racism pervading academic medical institutions. "We learned that there are things called health empires: medical schools and private hospitals that through affiliations (contracts with the city) operate and run city hospitals," wrote the New York State Chapter of the Young Lords. "These affiliations end up helping the medical school much more than the municipal hospital. For instance, interns and medical students have much more practice and experience in the city hospital, because in the private hospital, patients are treated by their own doctor and refuse to be treated by students. The poor people who come to the city hospitals are used as guinea pigs, sometimes, for new treatments, methods, new medicines that will then be used on the rich."[3]

Pointing to care provided in academic residency clinics (ARCs), the Young Lords decried the structural arrangements that allow wealthier patients greater access to experienced physicians, private practices, and continuity of care. The group's writings reflected its members' own experiences as ARC patients — experiences that still resonate today.

THE ACADEMIC RESIDENCY CLINIC

Since residency training began in 1889,[4] it has been challenging to balance the educational mandate to provide excellent training for tomorrow's physicians (in part by facilitating access to patients for clinical learning) with the societal mandate to provide high-quality care for today's patients. This balance has structural implications, because about 75% of academic health centers are located in underserved communities predominantly made up of racial or ethnic minority populations that are underinsured or uninsured.[5,6] Thus, "today's patients" tends to translate to "poor patients of color": poor Black patients with limited options are less likely to oppose being treated by a trainee than are affluent White patients with the resources and privilege to access any care they choose.

At the average ARC, patients face long wait times (as residents consult attendings), poor

continuity (attributable to residents' erratic schedules), and inadequate resources devoted to the care of patients with limited English proficiency or insufficient insurance.[7] ARCs often lack the resources, staff, and infrastructure to ensure adequate care for patients with complex needs.[8] For patients facing financial, physical, or emotional barriers to optimal self-care, ARCs must navigate conflicts between patients' needs and those of a health system that may be unable (or unwilling) to accommodate them.

These enormous challenges limit the quality of care. Patients seen by residents are more likely than those seen by attending physicians to have concentrations of glycated hemoglobin and low-density lipoprotein cholesterol that do not meet the target levels, to have higher rates of emergency department visits and hospitalizations, and to give lower ratings to their access to health care and provider communication.[8] Meanwhile, residents and directors of ARCs report high stress levels.[9]

The Young Lords hypothesized that ARCs provided inferior care because "the priorities for the medical schools are training and research [yet the] needs of the people are for mass, quality free health care" — the structural conditions and values of health care institutions "are often antagonistic."[3] In calling for fair and equitable access to experienced physicians and well-resourced clinics, the group anticipated academic health centers' transformation into an industry prioritizing research, training, and expansion over patient-centered care.

Some 20 years later, critical discussion of this tension among service, education, and research began to emerge in the medical literature. A 1993 article located the tension between medical school deans and academic hospital directors and called for academic health systems to unify under a shared vision.[10] Dozens of articles have since addressed this subject, and analyses have grown more nuanced.[11-15] Recent research suggests that though academic health centers have long served vulnerable communities with complex health needs, "the intractability of health inequities [requires them] to consider a more strategic approach to linking local partnerships and expertise to national regulations and standards."[16] Research further suggests that recent changes in financing and care delivery (e.g., value-based payment systems and new tax regulations for nonprofit hospitals) stress the need for medical centers to justify their benefit to local communities. In addition, the need to integrate considerations of social determinants of health into medical education demands greater community engagement.

DUAL LOYALTIES

To investigate how structural conditions contribute to health inequities, human rights–based approaches within medical ethics examine the sometimes conflicting aims of social institutions and health care providers. The "antagonisms" described by the Young Lords between patient-centered values and the structural conditions required to advance education, research, and profit are identified in bioethics as instances of "dual loyalty" — "a clinical role conflict between professional duties to a patient and obligations, express or implied, to the interests of a third party such as an employer, an insurer, or the state."[17] Dual loyalties constrain clinicians' ability to act in patients' best interests. The contemporary biomedical analysis does not generally address the fact, recognized by the Young Lords in 1970, that dual loyalties also reflect and perpetuate structural racism — a reality of which ARCs provided a case study.

One rationale for ARCs is financial: they allow academic health centers to employ their more affordable labor (residents) in the care of uninsured and underinsured patients and reserve their more expensive labor (attending physicians) for patients with private insurance. The inequity inherent in this two-tiered system became clear to the Young Lords as residency programs began proliferating in the 1960s and 1970s, transitioning from a selective to a universal form of postgraduate education. As physician-historian Kenneth Ludmerer has described, cracks began to appear in the residency system as it expanded. The autonomy traditionally afforded to trainees came with higher stakes as physicians' ability to treat sicker patients, prescribe more complex drugs with more serious side effects, and prolong people's lives grew, increasing the risks of mistakes and unintended harm. Simultaneously, faculty supervision decreased as more faculty became engaged in research.[4]

In response to the expansion of academic health systems and a growing understanding of "medical empires" and their limitations, activist physicians established community health centers

(CHCs) in 1975. Though it benefited underserved populations, the birth of the CHC further illuminated the structural racism of ARCs, which served populations similar to those of CHCs — with substantial health and social needs — but without the enhanced Medicaid and Medicare reimbursements granted to federally qualified health centers (FQHCs),[18] and hence with fewer resources, lower staff-to-patient ratios, and limited team-based systems of care.

AWARENESS, ALIGNMENT, ADVOCACY, ACCOUNTABILITY

The adverse effects of dual loyalties in academic medicine echo and extend a long history of racial capitalism. Harkening back to medical experimentation on Black and Brown bodies, the disproportionate burden of health risks arising from dual loyalties represents similar exploitation of marginalized communities.[19,20] The normalization of this insidious process reifies the notion that some populations are expendable. ARCs need not perpetuate such racism, but making the ARC model more just and equitable will require awareness, alignment, advocacy, and accountability.

Awareness means ensuring that everyone from high-level administrators to frontline workers can recognize structural racism. Experts have increasingly been publishing descriptions and case studies of structural racism,[21] though its intentional invisibility can make it difficult to understand. It may be helpful to compare normalized sites of structural racism, such as ARCs, with sites that are generally recognized as violent, such as prisons.[22,23] Indeed, a telling intellectual exercise is to consider whether ARC patients have more in common with private-practice patients or with prisoner patients.

Institutional leaders play central roles in the day-to-day functioning of their organizations,[24] and leaders who are just awakening to institutional-level manifestations of structural racism can learn from those who've begun addressing institutional racism. One successful example is Montefiore Medical Center, where, in 1970, a group of physicians created the Residency Program in Social Medicine. Affiliated with Albert Einstein College of Medicine, this program has produced physician-leaders in pediatrics, family medicine, and internal medicine who have gone on to center antiracist practices in their work.[25] The culture of these outpatient-based residency programs has spread throughout the institution. In 1998, Montefiore president Spencer Foreman, who was also chairman of the Association of American Medical Colleges (AAMC), spoke at the AAMC's annual meeting about the social responsibility of academic medical centers, outlining an agenda for better aligning institutions' priorities with societal needs. Institutions should, said Foreman, identify a community and build a network of primary care to respond to its needs, build a critical mass of faculty who are well trained in clinical medicine and population health and are excited to inspire and engage medical students in caring for people living on the margins, and build a body of community-based research that interrogates the community's health and needs, informs services provided and new research questions, and evaluates performance in improving community health.[26] When Steven Safyer, a graduate of the social medicine program, became president of Montefiore in 2008, he expanded the ambulatory care network throughout the Bronx, including into schools, shelters, and other locations.[27]

Some institutions have built on these principles by inviting their local community into the academic space and valuing the expertise conferred by lived experience. For example, Chicago's Community Grand Rounds, a partnership of the University of Chicago, Northwestern University, and community organizations, is a seminar series that empowers the community to engage with academic health centers on population health topics, helping to target interventions more effectively and generate more relevant research questions.[28]

Beyond awareness, ARCs require alignment of physicians' roles and responsibilities with patients' needs. Physicians working at ARCs face conflicting pressures; beyond patient care responsibilities, they must oversee residents, participate in faculty meetings, and undertake scholarly activities to ascend the academic ladder. Improving the quality of clinic care is rarely a priority and is virtually never reflected in a positive light on a physician's profit-and-loss statement. If ARC physicians' responsibilities are to be aligned with patients' needs, they will have to be afforded similar time, space, and prestige as academic researchers.

Any additional resources are most likely to emerge from physician advocacy in the form of grant writing, pilot projects, and unpaid super-

vision of additional staff. At Brown University's internal medicine residency clinic, clinical leaders have advocated for a compensation model not based on relative value units. Attending physicians are asked to have eight patients scheduled during each clinical session but are not held responsible for no-show rates. This policy allows physicians to provide high-quality care and promotes a focus on quality improvement during administrative time. Clinic physicians have been able to supervise grant-funded community health workers in supporting patients who have a history of incarceration, substance use disorder, or both; to build novel programming, including a Social Medicine Assistance Clinic that helps patients apply for housing and advocates for patients facing criminal charges or court debt; and to oversee volunteers from the AmeriCorps VISTA program tasked with building clinic capacity to address population health. None of these activities, however, generate revenue in a way that compels the academic health system to support physician time spent on these tasks, so the agreement allowing 30 minutes for each patient visit and not penalizing physicians for no-shows is just the beginning of creating a patient-supportive system.

It's also important to realign the goals of training with outpatient care. Most residency programs prioritize inpatient-based curricula even though the majority of clinical medicine occurs in outpatient settings.[29] Shifting residency toward an office-based model better serves both trainees and patients. "Clinic is the curriculum" is the motto of one health system that prioritized outpatients in restructuring residency schedules and curriculum and in generating excitement among residents and attendings for primary care. One practical aspect of this transformation was capping the preceptor-to-resident ratio at 1:3, which resulted in both a better teaching environment and higher-quality care.[30]

Academic health centers cannot do this work alone: advocacy is needed, since policymakers help shape the systems that perpetuate structural racism. Since ARCs and FQHCs care for similar populations, academic physicians can advocate for ARCs to qualify for enhanced Medicaid and Medicare reimbursements. Policymakers could then require ARCs to maintain certain standards and ranges of services and to monitor the relative quality of care provided by residents and attendings and intervene when clinically significant disparities are identified. Furthermore, residency programs could be encouraged to first explore partnering with an FQHC for outpatient-based training; if a partnership proved infeasible, they could apply for enhanced reimbursements for an existing ARC. Such policy changes would have important downstream effects in a country with a primary care shortage: a better-resourced, higher-functioning outpatient training environment would encourage more trainees to pursue primary care careers.

Another opportunity for advocacy is at the level of the Accreditation Council for Graduate Medical Education. For instance, current internal medicine program requirements specify that residents spend at least one third of training time in ambulatory settings and at least one third in inpatient settings. Increasing the ambulatory care requirement to at least 50% would better align education with societal need and lead to improved continuity of care, increased comfort with outpatient practice, greater focus on outpatient quality-improvement initiatives, and more residents pursuing primary care.[31]

Finally, ARCs need to be held accountable. The Young Lords understood that dual loyalties could be mitigated, and true accountability achieved, only if an ARC's governing body and patient population were one and the same.[32] Though this goal seemed lofty in 1970, there is now a precedent for such community governance: Dr. H. Jack Geiger's CHC model. Established as nonprofit organizations, CHCs were governed by boards on which a majority of members were clinic patients; the patient community thus had "the power to set policy, hire and fire executive leadership, and chart their center's strategic course."[18] Applying a similar funding condition to ARCs would instill a sense of ownership in patients and unite physicians and patients in service to the community.[32]

CONCLUSION

Shortly after occupying Lincoln Hospital, the Young Lords created Lincoln Detox, a unit where patients could detoxify from substances such as heroin without Western-medical interventions.[32] Calls for community control led to a patient-centered treatment facility that offered an alternative to the status quo. Community ownership of ARCs would redress the unequal distribution of and access to medical knowledge by enabling

the interchange of knowledge: the technical knowledge of clinicians on the one hand, and the grassroots knowledge and lived experience of patients and community health workers on the other.

The current moment has taught us that discussion about radical change in support of the well-being and betterment of all is possible. Although consistent change has not yet emerged from this discussion, perhaps academic health centers and their residency clinics, in partnership with their patients, can lead the way.

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