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# How U.S. Hospitals Often Undervalue Black and Poor Lives

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In the early morning hours of December 21st, 2015, a 57-year-old black woman named Barbara Dawson died at the Calhoun Liberty Hospital in Blountstown, Florida, after being forcibly discharged from the hospital's Emergency Room just minutes before. According to the local police chief, Dawson was "causing a disturbance in the hospital with her language and the volume of her voice." Dash-cam video from a police car outside the hospital, released on January 7, captures Dawson pleading with police officers as they arrest her for trespassing: "I can't breathe! I can't breathe. Please sir, I beg you." In handcuffs, Dawson collapses feet from the car, as an officer and nurses continue to try to wedge her inside. She lies on the ground for between ten and twenty minutes before she is offered medical assistance. According to the medical examiner in Panama City, a blood clot in her lungs was the cause of death.

Several local and state agencies have begun investigations into the incident, as has the local chapter of the National Association for the Advancement of Colored People. Even after these investigations are completed, we may not fully understand what led to Ms. Dawson's death. Yet her struggles offer a troubling reminder of the ways in which hospital care still continues to be denied to those who need it, almost six years after the passage of the Affordable Care Act. Since 1986, federal law has mandated that emergency rooms stabilize all patients who arrive, regardless of their ability to pay. This ambiguous injunction has left hospitals with an enormous amount of discretion about who gets care, and how much is sufficient. Uninsured patients are often given only the absolute minimum of care, if any at all, as they are hurried out the door.

## Hospital Dilemmas in a California City

This is not just a problem for Florida, even if difficulties there are made worse by the refusal of the state to accept federal health reform money to expand Medicaid to the near poor. My own research on these issues focuses on three hospitals in a small northern California city – all of them operating in one of the most liberal cities and states in the country. Even in these hospitals, I saw firsthand how hospitals, and the doctors and nurses who work within them, struggle to reconcile the basic right to health care with the profit motive on which American health care increasingly is based.

My research shows that shortfalls in care for the most vulnerable can take very different forms based on hospitals' structures, cultures, and organizational histories.

- At the Catholic Hospital I examined, emergency room doctors were responsible for their own billing, giving each doctor a personal financial stake in avoiding uninsured and underinsured patients (or those they thought were *likely* to fall in these categories). Doctors told me about the cues some used to maximize their economic interests as they selected patients to treat. They avoided Latino last names, for example, or privileged "blunt traumas" (likely to be from falls or car crashes) over "puncture traumas" (likely to be gun shots or stab wounds). Ironically, however, these same doctors were acutely aware of the "charity care" they *did* provide, since the cost of that care came directly out of their own pockets.

- The tension was less salient for individual emergency room doctors at the other two hospitals with collective billing arrangements. Nevertheless, these departments also sought subtle ways to minimize dealings with the poor. At the integrated health facility I studied, the emergency was legally open to the public, but that is not widely known and the system did little to advertise it. Emergency rooms at the other two hospitals are easily visible from the street, but the emergency room at the integrated facility was at the back of the medical complex. At a community meeting about emergency care in the city, the head of the Catholic Hospital suggested—tongue in cheek—that pressures on the other two hospitals could be alleviated if the integrated health system invested in better signage for its emergency room.

- The third hospital had been a public facility administered by the county until a chain took it over in the late 1990s. Historically, this hospital had the emergency room on which the poor depended most. But since the takeover, the facility has tried to rebrand itself, in part by distancing itself from the poor. "Somebody has to take care of [the indigent], and we're proud to do it," said one administrator, "but we don't want to only be seen as, 'Oh, that's where all the poor people go.'" With some embarrassment, she described a telling incident. When a student from a nearby private high school was hit in the face by a baseball and arrived at the emergency room as a "very well-insured, wealthy patient," another patient down the hall was a disruptive prisoner accompanied by four police officers. After hearing this prisoner "cuss, swear up and down," the student's mother filed a "huge complaint" with the hospital. How was the hospital to attract the insured if it had to take care of the disruptive as well?

## Financial Pressures on Patient Care

Although we do not know for sure, it seems likely that in Florida hospital staff prejudice towards Ms. Dawson's race and weight (at 270 pounds) may have influenced the events leading to her death. But we should not overlook the possibility that hospital policies may also have mattered. As of 2005, Calhoun-Liberty Hospital was in dire financial shape, but the hospital has recently increased its revenues and won some praise for its executive team (until the chief executive officer was investigated for embezzlement). Did the changes that contributed to the hospital's rosier financial profile come at the expense of care for uninsured or underinsured patients?

In the past, U.S. hospitals burdened with high numbers of uninsured or underinsured patients have received extra "disproportionate-share hospital funding" from state and federal government. Now, however, as national health reform takes effect, such special funding is dwindling by law, on the assumption that Affordable Care reforms would increase the number of insured patients at these hospitals. Paradoxically, patients who continue to be uninsured can find it even harder to get the care they need – for example, if they are undocumented immigrants or if their state government, like Florida, refuses to implement Medicaid expansion. Today, both market pressures and government rules hold hospitals accountable for reducing costs and providing care "efficiently." As incentives to care for poor, minority, and difficult patients continue to shrink, the contradictions between care-giving missions and the market realities faced by U.S. hospitals are unlikely to be resolved anytime soon. Read more in Adam Reich, *Selling Our Souls: The Commodification of Hospital Care in the United States* (Princeton University Press, 2014).



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