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# Disparity in Access and Poorer Health Status in Non-Majority Populations

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## **Abstract**

North America is a large, diverse continent, which has a longstanding history of inequality for its diverse population. These historical inequalities continue to impact health outcomes and access to healthcare for non-majority groups. To ensure the best healthcare outcomes for patients, pediatric orthopaedic surgeons must be aware of these inequities in order to combat them and minimize their effects.

## **Key Concepts**

- Understanding the history of systemic inequalities in our healthcare system is key to understanding our present situation.
- These historical inequities affect all fields of medicine, including pediatric orthopaedics.
- As pediatric orthopaedic surgeons, we have a responsibility to take an active role in moving toward full health equity.

## **The History of Racial Discrimination in U.S. Healthcare**

The history of race-based inequity in healthcare is perhaps the most obvious and well known. Until 1964, race-based discrimination was explicitly codified into hospital practices across the United States, particularly in the Southeastern U.S., which contained the largest population of African

Americans at the time.<sup>1</sup> The system separate hospitals for Black and White Americans, with Black hospitals having significant shortages in staffing and funding compared to their white counterparts.<sup>1</sup> Dr. Martin Luther King, in a 1966 speech at the Medical Committee for Human Rights in Chicago stated, "Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane."<sup>2</sup>

This inequitable healthcare system was challenged within the framework of the larger 1960s civil rights movement. Title VI of the 1964 Civil Rights Act prevented any discrimination based on “race, color, or national origin in any program or activity that receives federal funds or other federal financial assistance.”<sup>3</sup> These federal funds came to include Medicare and Medicaid payments, meaning any hospital wishing to accept these recently introduced but already extremely popular programs had to desegregate immediately.

While the ruling led to an end to explicitly segregated hospitals, it did not lead to full health equity for America’s minority racial populations. Recent studies, more than 50 years later, continue to show health disparities in life expectancy, adult mortality, and childhood mortality among Americans based solely on their race.<sup>4,5</sup> These disparities demonstrate that more insidious forms of systematic racism remain within our healthcare system.

## The Medical Establishment and Women’s Rights

The history of the women’s rights movement and its interaction with the medical establishment has largely revolved around reproductive health and ideas of bodily autonomy. In 1916, the first birth control clinic was opened by Margaret Sanger in Brooklyn, NY.<sup>6</sup> At that time, she shared only advice, information, and education to women regarding birth control, as oral contraceptives were not yet invented, and essentially all other birth control methods were illegal. Nine days after the opening of the clinic, it was raided and shut down, and Sanger spent 30 days in jail.<sup>6</sup>

Oral contraceptive pills were developed in 1953. Initially, these were tested on poor women in Puerto Rico, due to laws banning birth control for consenting adults in most of the United States.<sup>7</sup> In 1965, as a result of the Supreme Court decision in *Griswold v. Connecticut*, birth control pills became available to women but only if they were married and with their husband’s permission.<sup>8</sup> In 1973,

## INEQUITIES IN MEDICINE: A HISTORY

**1916**

### First Birth Control Clinic

Margaret Sanger opens the first U.S. Birth Control Clinic in Brooklyn, NY. Nine days later the clinic is raided and shut down by authorities.

**1964**

### American Civil Rights Act

Title IX of the American Civil Rights act prohibits federal funding, including Medicare dollars, at any segregated facility.

**1965**

### Griswold V. Connecticut

Supreme court ruling that first legalized oral contraceptives. Initially this applied only to married women, and only with their husbands permission.

**1972**

### Dr. John Fryer and the APA

In 1972 Dr. John Fryer came out as a gay psychiatrist at the American Psychiatric Association annual meeting. As a result of his speech, homosexuality was removed from the DSM in 1973

**2012**

### Gender Identity Disorder

"Gender Identity Disorder," a diagnosis given to transgender individuals, is finally removed from the DSM.



**Figure 1.** Dr. John Fryer, a.k.a. “Dr. Henry Anonymous,” right, during the 1972 annual meeting of the American Psychiatric Association in Dallas, TX. Dr. Fryer risked his career to speak out against the classification of homosexuality as a mental disorder. Photo credit: Kay Tobin, via Manuscripts and Archives Division, The New York Public Library.

birth control was legalized for unmarried women and later that year, saw the landmark Supreme Court case of *Roe v. Wade*, which guaranteed a federal right to abortion services. These battles over access to reproductive care continue to this day.

### **Sexual Orientation and Gender Identity in Healthcare**

The LGBT+ rights movement in the United States is considered by many to have started with the Stonewall Riots, which occurred in New York City in 1969. At that time, homosexuality and gender diversity were pathologized as mental illnesses in the *Diagnostic and Statistical Manual of Mental Illness (DSM)*.<sup>9</sup> In 1972, Dr. John Fryer came out as a gay psychiatrist at the American Psychiatric Association annual meeting in Dallas, TX. To do so at the time, Dr. Fryer risked loss of his medical license and his career, as gay relations were criminalized in 42 states.<sup>9,10</sup> Due to the risks to his livelihood, Dr. Fryer gave his speech in a Richard Nixon mask, oversized tuxedo and wig, and was introduced

to the audience as “Dr. Henry Anonymous.” In his speech, he acknowledged the risk to his career in order to speak out against the classification of homosexuality as a mental disorder (Figure 1). “We are taking an even bigger risk, however, in not living fully our humanity,” he said. “This is the greatest loss, our honest humanity.”<sup>9,10</sup>

As a result of Dr. Fryer’s impassioned speech, homosexuality was removed from the DSM in 1973.<sup>9,10</sup> However, the struggle for LGBT+ rights continued, and “Gender Identity Disorder” remained classified as a mental illness in the DSM until 2012.

### **Health Equity in Orthopaedic Surgery Today**

While great strides have been made in the fight to eliminate inequities within the medical establishment, the legacy of these systems remains in the form of prejudices and systemic biases. Recently there has been an explosion in interest and study on health disparities in medicine, which demonstrate continued inequities within

all subspecialties of medicine, including orthopaedic surgery.

Hip fractures are among the most common operatively treated fracture in the United States and have some of the most robust studies on outcomes. This makes hip fractures one of the best examples of race-based disparities in outcomes within orthopaedics. Multiple studies have shown that non-white patients with hip fractures experience increased time to surgery, increased 1-year mortality, and decreased independent ambulation following fixation, compared to their white counterparts.<sup>11,12</sup> Non-white patients with hip fractures also experience significantly longer wait times between ED arrival and initial radiographic imaging than white patients with hip fractures.<sup>13</sup>

Within pediatric orthopaedic surgery, there is evidence of race-based health inequities as well. A 2020 study demonstrated that non-white children and children with public insurance had significantly longer wait times between injury and initial orthopaedic evaluation for fractures managed as outpatients.<sup>14</sup> Another study found that non-white children were significantly less likely to be prescribed pain medication for long-bone fractures when being discharged from the ED.<sup>15</sup> A 2022 study found that non-white patients who were prescribed a brace were significantly less likely to actually receive the brace compared to white children.<sup>16</sup>

Perhaps one of the most important studies on bias within pediatric orthopaedic surgery is a 2002 study published in *JAMA* on rates of reporting suspected child abuse among children with fractures.<sup>17</sup> In this study, charts were retrospectively reviewed by a reviewer blinded to the child's race or ethnicity and determined likelihood of abuse. Minority children were significantly more likely to have a skeletal survey ordered and child protective services alerted, even when controlling for insurance status and independently determined likelihood of abuse.<sup>17</sup>

Despite the expanding body of research that demonstrates continued racial inequities in orthopaedic care, there is

some evidence that many orthopaedic surgeons still fail to realize the scope of the problem. A 2016 study titled "Perspectives of Orthopaedic Surgeons on Racial/Ethnic Disparities in Care" found that only 12% of orthopaedic surgeons believed that patients often receive different healthcare based on their race, only 9% believed it occurred within orthopaedic care specifically, only 3% within their hospitals or clinics, and only 1% in their own practices.<sup>18</sup>

Recognizing the barriers, prejudices, and biases that minority patients face is becoming increasingly important for pediatric orthopaedic surgeons because the populations we treat are becoming increasingly diverse. While 71% of baby boomers identify as white, that number decreases to 59% of Gen X, 55% of millennials, and only 50.1% of Gen Z.<sup>19</sup> Additionally, the percentage of adults identifying as LGBTQ+ has doubled since 2012, from 3.5% to 7.1%.<sup>20</sup> Again, there are stark generational differences, with 10.5% of millennials and 21% of Gen Z adults identifying as something other than straight.<sup>20</sup>

As pediatric orthopaedic surgeons, we have the great privilege of taking care of a vulnerable, but incredibly rewarding, patient population. With this privilege comes a great responsibility to ensure we provide the optimum care to our patients. That responsibility includes recognizing the systematic biases that remain embedded within our healthcare system as a result of historical discrimination and taking an active role in moving together into a more equitable future.

## Disclaimer

The author has no conflicts of interest to report.

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