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# Profiling in the Emergency Room

## Introduction

America is a nation based on complex and often contradictory ideas about class, equality and the opportunity for "success." On the one hand "the American Dream" is a narrative meant to demonstrate that anyone can become successful with hard work, persistence and determination. The sentiment in the Declaration of Independence, that in a democracy "all men are created equal" was meant to reflect and inspire just such an ideology and practice. Yet we also live in a culture of Capitalist hierarchy with a consistent and indeed a growing gap between the haves and the have-nots. As early as 1904, Max Weber, "the father of Sociology" wrote *The Protestant Ethic and the Spirit of Capitalism.* In this translated text—widely considered a founding text in economic sociology—Weber explored the Calvinist influence that inspired Americans to value and engage in work in the secular world. This shift in ideology for Weber was central to the development of capitalism and the value of working hard to compete, to transgress (and thus reify) class distinctions. This aesthetic shifted from positioning poverty as a state of pious grace to positioning work and wealth as "Godly" or at the least "natural and productive" for individuals who ultimately have more, do more and thus count more than others in late industrial capitalism.

In many ways then—and despite common class denial—the ideology of equality amongst the people of the United States both over shadows and reflects the reality of class. Classes in America are present and more often than not, the social hierarchy is not a ladder that can be easily climbed. Many factors determine an individual's class and once a person is a part of one social class it is unlikely they will be able to climb or fall to a different tier in society's social hierarchy. Social mobility correlates to access to education, jobs available and family history.[1] The relationship between social class and family history can hinder an individual fluctuating to a different social class at some point in their life. It is more likely that if an individual is born into a certain family there will be a certain set of resources available that will likely shape the individual to live a life just like the one provided from birth.[2] Although economic growth might not be directly correlated to class mobility, the idea of the American Dream is becoming less likely because Americans are not always provided with the resources necessary to "climb" the social ladder in today's society. In today's day and age it is inevitable that an individuals' social class determines and shapes their experience of the world. Social class does matter. It is an underlying factor in every aspect of an individual's life. Social class influences overall family life, education and healthcare.

Although we would like to think that families are not affected by their standing in the social hierarchy many investigators have proved otherwise. Social

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[1] Breen, Richard. "Inequality, Economic Growth and Social Mobility." T*he British Journal of Sociology* , Vol. 48, No. 3 (Sep., 1997), pp. 429-449
Published by: Wiley-Blackwell on behalf of The London School of Economics and Political Science

[2] Ibid.

class leads family members to assign different meanings and values to their behaviors and life circumstances.[3] In a 1996 study by Robert Hughes, researchers looked at family life differences from a cultural and structural perspective. A cultural approach looked at the values and goals that are most common among certain classes. These values change depending on a family's position in the social hierarchy. "Upper class" families in this study could afford literally and metaphorically to have more specific values and loftier goals for their families. A structural perspective looks at how families of different social classes embrace particular values, "as a way to cope with the opportunity structure in our society".[4] Family researchers and practitioners examined families earning a median income. In 1988 this median income was $32,000. Over time the proportion of families that feel near the median declined and the proportion of families that fell significantly below and above increased therefore showing how the social class in the United States has been treading towards greater inequality. The inherent class structure in America comes with inherent differences in terms of access to opportunity (including education, healthcare, and physical security).

The social class system is affected by the poverty, but what many experts are claiming now is that the economy creates and exacerbates static class hierarchy rather than bridging class gaps.[5] The economist Joseph Stiglitz, has commented on how there has always been inequality amongst the different social classes but

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[3] Hughes, Robert Jr. et. al. Social Class Issues in Family Life Education**.** *Family Relations*, Vol. 45, No. 2 (Apr., 1996), pp. 175-182.
[4] Hughes, Robert Jr. Ibid.
[5] Ryssdal, Kai. Interview: Economist Joseph Stiglitz on income inequality in the U.S. Marketplace: Wealth and Poverty. 2 May 2012. Accessed online 13 August 2012.

currently the gap between the super-rich and everyone else has increased to a new magnitude. Economists, like Stiglitz, have proposed, "Growing inequality is the flipside of something else—shrinking opportunity.[6] The United States wants to be "the land of opportunity" yet as the inequality increases there is less opportunity. Less opportunity means that the individuals being born in the lower social classes, with parents are likely poor and not well educated, will live a life just like their parents, at the bottom. Individuals being born in the lower classes are not able to live up to their potential when there is little opportunity and vast gaps between the social classes.

As Howard Steven Friedman points out in the *Huffingon Posts'* "The American Myth of Social Mobility," most Americans "cherish our national legends about the American dream" and have "greater faith in their country being a meritocracy than citizens of nearly every other country on earth." Yet, as Friedman notes, most all studies have shown that the United States has a lower and not a higher class mobility than other countries. One pivotal comparative study that Friedman points to demonstrated that among "advanced countries " (Denmark, Sweden, Finland, Norway, the United Kingdom and the United States) the US had the lowest rate of class mobility: 42% of American sons of father's born in the poorest quintile landed in the poorest quintile themselves. This rate of persistence of poverty was far higher the 25-28% range found in Scandinavia or even the 30 % found in the UK.

At the same time, as David Dayen reports in "Myth of American Upward Mobility Punctured, "just 8 percent of American men at the bottom rose to the top

[6] Ibid.

fifth (compared to 125 of British and 14 % of Danish men.) Despite that fact that many Americans think of themselves as living in a class blind society, about 62% of Americans (male and female) raised in the top fifth of incomes stay there and 65 percent born in the bottom fifth stay there, according to research by the Economic Mobility Project of the Pew Charitable Trust. Dayen goes as far as agreeing with Jason De Parle, as noting that "upward mobility doesn't really exists in [The United States} any more."

**Classed Practices**

Marvin Kohn, a highly regarded sociologist has spent a lot of his career investigating how perspectives and values change amongst families in particular social classes. Kohn's theory that upbringing reflected social class was supported by finding that working classes are mainly concerned with keeping their children out of trouble. In his 1970 study entitled "Class and Conformity. A Study of Values," he found that for the poor, punishment is often physical. In comparison, Kohn found that middle class parents often reason with their children as a form of discipline.[7] The reasoning is not solely to keep children out of trouble but to encourage good behavior.[8] Middle class parents use warnings and threats rather than physical punishment which then places greater emphasis on independence and achievement. Parents raise their kids partly consciously and partly subconsciously to grow up to

[7] Kohn, Melvin L. et al. Class and Conformity. A Study in Values. *Science* 11. Vol. 170 no. 3963. Pp. 1183-1185. December 1970. Accessed Online 10 August 2012.
[8] Henslin, James M. Sociology: A Down-to-Earth Approach 10e. p. 70-72. Online. Accessed 10 July 2012.

be just like them. As research I covered earlier indicates, despite society's claim that children can achieve anything if they set their minds to it, parents most often raise their children to be in the same social class as they are. Kohn's study suggests that parenting reflects and reinforces social class. Starting from an individual's adolescence, in their home by their parents, the individual consciously or subconsciously is being brought up to be in the same position on the social ladder as their parents. This cycle and trend has been true for many generations and as many family researchers are finding, this upbringing could be one reason that inequality and gaps between social classes are increasing. The American dream that many embrace in theory, in reality is simply a myth when compared to the reality of a growing class disparity and class immobility,

An essay by Jean Anyon called Social Class and the Hidden Curriculum of work is a pivotal essay that reported the differences in elementary education amongst children of different socioeconomic backgrounds. Anyon visited five different elementary schools and demonstrated how these students received different educations based on the financial status of the neighborhoods the schools were located in. The teachers taught children in a tailored way that reflected the jobs the children would most likely have in the future. Anyon's study showed how teachers made judgments about a student's future because of their background, their class realities. This type of profiling leads to the concept that although American claims, "All men are created equal", in reality even children are treated differently in the education system depending on the class of their families.

Anyon first looked at two working-class schools and noticed how the teachers instructed their students in preparation for future working-class jobs. Most of the students had parents with blue-collared jobs. About 15% of the fathers were unemployed and the rest had working-class jobs, for example stockroom workers; foundry-men, pipe welders, ect. The average income was around $12,000.[9] When observing the teaching strategies at these two schools Anyon noted the teachers presented procedures mechanically, there was very little decision or choice making done by the students. Instructors did not explain why the work was being assigned nor did they connect it to other concepts being taught in the class. The work was consciously presented in a step-by-step process. In preparation for anticipated working-class jobs, the students were supposed to first and foremost follow the steps. The students were not encouraged to think independently and were not evaluated on the thought processes being developed (or challenged) but on being "right or wrong" and on the degree to which they had followed the right steps.[10]

The third school was categorized as the middle-class school and the children came from three different groups. Some children were from families who were "rich" blue-collar workers, for example carpenters, painters, and plumbers; another group was titled working-class and middle-class white collar jobs; for example women in office jobs, supervisors in industry and parents employed by the city. The final group represented in the middle-class school was titled "middle management."

[9] Anyon, Jean. "Social Class and the Hidden Curriculum of Work". *Journal of Education,* Vol. 162, no. 1, Fall 1980. Online. Generative.edb.utexas.edu. Accessed 1 July 2012.
[10] Anyon, Jean. Ibid.

Anyon found the income for this school ranged between $13,000 and $25,000 in 1980 dollars. At this "middle-class school" Anyon noticed that it was less about following the right steps and more about getting as many right answers as possible. Although there was some individual thinking and decision making there was little creativity required or allowed. The work in all subjects was rote and minimally engaged. One student from this school was quoted as reflecting that what you do is "store facts up in your head like cold storage- until you need it later for a test or your job."[11] This type of thinking demonstrates the children from these schools were taught and came to understand that they needed to remember enough facts to do well in order to receive rewards like a good job or entry into a technical college.

The fourth school observed was deemed the "affluent professional school." The children who attended this school were expected to be predominantly from families who had an upper income level in the middle class. Most children were from families who earned an annual income within the range of $40,000 and $80,000 in 1980 dollars. These students had parents who were cardiologists, interior designers, lawyers or engineers. A majority of the work in this elementary school was creative activity and each student did their work independently. With each activity the students were asked and encouraged to apply previously learned ideas and concepts. On the whole the schoolwork involved a more independent thought and expression than did classrooms in the other schools. Instead of steps or rules that were emphasized in the "working and working middle class schools, these wealthier students were presented with guidelines and limitations that they were

[11] Anyon, Jean. Ibid.

simultaneously encouraged to rethink and transgress (thinking "outside of the box"). Instead of being judged on the number of right answers a student could accumulate and regurgitate on tests, these students were evaluated on the quality of the works expression and "for the appropriateness of its conception to the task"[12]. All the students in this class were encouraged to make sense out of and critique the lessons and formulate new ideas. This style of teaching and learning prepared students for "affluent professional" jobs like those of their parents.

The final school that Anyon observed was titled the "executive elite school." Most of the fathers of the children who attended this middle school were top executives in major United States-based corporations; for example, AT&T, Citibank and American Express. The entire student body was Caucasian and the average incomes of the families who put their children in this school was between $100,00 and $500,000 (in 19?? Dollars). This school represented the upper one percent of the families in the United States.[13] Learning at the executive elite school was focused on preparing the students for a life where they would be the leaders, the thinkers, the CEOs and top executives at important businesses and corporations. The teachers explained their pedagogies for these students that would teach them "to achieve, to excel and to prepare for life."[14] Instead of providing the students with the "correct" answers after an assignment was completed the class went over their answers and students stated if they disagreed with an answer one of their classmates received. This correction process forced students to reason and to

[12] Anyon, Jean. Ibid.
[13] Anyon, Jean. Ibid.
[14] Anyon, Jean. Ibid.

question rote knowledge and ideas. The students learned to support their answers with sound logic and they were taught that it is ok to disagree, provided you have an idea that makes sense. This was critical and creative thinking—central to leadership—at its very best.

As early as elementary school then, America is teaching and shaping the minds and bodies of younger generations according to their class. Although the teachers certainly had the best intentions in preparing their students for their futures, they were in fact both reflecting and reifying class divisions, even as they were purporting that each of us can do anything, and be anything, if we set our minds to it and work hard. Yet the reality is that if you are born into a certain status of wealth, he numbers are simply against you from the start. Anyon showed through her study that education is fueling the class system in America. Whether this is for the greater good is not important. Society is preaching and not following through with practice. Class largely influences education; therefore, as early as elementary school children are aware of where they are "ranked" in our country.

Systems like education work together to both reflect and reify class in late industrial America. Medicine is no exception. Keeping healthy and seeking out the best medical care is in most cases easier and most productive if an individual is wealthy. Profiling in hospitals, especially in emergency rooms is an infectious trend in our health care system demonstrating to society yet again that contrary to the prevailing ideology, not all men or women in America are created equal.

Janny Scott, a correspondent for *The New York Times*, conducted a fascinating study to determine that class not only dictates what treatment you receive but also

the way our medicalized bodies are produced, marked and patrolled through class distinctions. Her research, presented in the New York Times series and book, "Life at the Top in America Isn't Just Better, It's Longer" describes this phenomenon. Researchers for this study followed three New Yorkers who had almost nothing in common, except that they each faced the same threat of a heart attack. The author followed the three individuals through their treatment and recovery, observing how from the beginning their experiences diverged tremendously because of their real and perceived social class. This project really demonstrated how benefits from medical advances go disproportionately to what society deems the, "upper class." Scott's exposé demonstrates that education, wealth, assets and supports position some as "invariably in the best position to learn new information early, modify their behavior and take advantage of the latest treatments and have the cost covered by insurance"[15] while poverty gravely disadvantages others. Scott's work exposes the reality of our nation's socioeconomic distribution and our health care system. It is clear from her study with those with more education and better jobs and connections are more likely to seek out the best help, be insured and take control of their health yielding better outcomes.

In "Life at the Top" Scott followed three New Yorkers, a wealthy architect, a middle class utility worker and a maid. The upper-class architect, Jean Miele was given some of the best possible care and overall he was in control of his recovery. Miele had the advantage of being more affluent with a good job therefore when he collapsed from his heart attack in Midtown Manhattan there were many major

[15] Scott, Janny. "Life At the Top in America Isn't Just Better, It's Longer". Class Matters. *The New York Times.* p 29.

hospitals near by. Miele was given a choice by the first responders on what hospital he wanted to be taken to; he picked Tisch Hospital that is a part an academic center with affluent patients. By making this choice Miele opted not to go to Bellevue Hospital that is city-run and has the busiest emergency rooms in New York.[16] Miele was a perfect example of how more educated people with better jobs will take control of their health and choose to go to better hospitals in order to receive better care. By choosing Tisch, Miele was correctly profiled as an affluent patient and given the best care he could ask for in New York. Turning down Bellevue Hospital Miele avoided an extremely busy Emergency Room and the risk of not being treated appropriately whether or not he was insured.

The middle class utility worker, Will Wilson, was also given a choice of hospitals, but because he lived in Brooklyn the emergency medical technician gave Wilson the choice of two local hospitals. The two local hospitals were not able to provide the same level of care as that which Miele received because neither hospital had state permission to do angioplasty, the preferred treatment when an individual has a heart attack.[17] Wilson turned down Woodhull Medical and Mental Health Center, the city-run hospital that is responsible for serving three of Brooklyn's poorest neighborhoods. Instead of going to a hospital that serves some of the poorest individuals in New York City, Wilson elected to go to Brooklyn Hospital Center, although the treatment he received here did not work and he had to be transported the next day to a hospital in Manhattan, a more affluent area, to receive angioplasty, the treatment Miele received within two hours of having his heart

[16] Ibid. p 39.
[17] Ibid. p 32.

attack.[18] Wilson was able to receive the best type of treatment eventually but being a middle class utility worker, he was only initially given the choice between two hospitals that could not offer the best care.

Gora, an uninsured maid, received the care with the poorest outcome because of class profiling by the hospitals and the assumptions of Gora's financial and social status as well as her lack of insurance. Unlike the other two individual Scott followed, Gora was not given a choice of what hospital to go to and was just taken to Woodhull hospital. Woodhull hospital is the facility that the utility worker, Wilson, turned down and it is also the hospital that takes care of some of the poorest individuals in New York City.[19] Both Miele and Wilson were seen right away when they were taken by ambulance to a hospital while Gora was not seen by a doctor until two hours after she arrived. It was not until a few hours after being seen that Gora's tests came back confirming that she was having a heart attack. After medicating Gora the hospital was going to see what the risk of a second heart attack was but Gora became ill and ended up going home and never getting these preventative tests done. Her knowledge of her health and the health system, her real and perceived class position, and her lack of resources all worked to her disadvantage.

Ewa Gora was likely an individual who lived well below the poverty line and she was uninsured. This lead to her being taken to an inferior hospital and receiving lesser care that the physicians and medical professionals felt was more appropriate to her "station in life." Even when she did finally receive treatment it was not nearly

[18] Ibid. p 33.
[19] Ibid. p 33.

as effective as was Wilson's and Miele's care. The preventative tests were never completed and ultimately Gora ended up costing the health care system so much more money because she relapsed. The second heart attack could have been prevented if the doctors had enforced the tests, if Gora could have afforded the tests or if she had been made to understood the imperative of the preventative medicine and it's positive impact on her lifestyle. Gora did not truly understand how to keep herself healthy and because the further tests were not done initially she had a second heart attack.

From start to finish the treatments of these three New Yorkers was drastically different. After receiving his top-notch treatment, within minutes of having his heart attack, Meile was financially stable to take all the time off work that he needed. Beyond this Meile could afford to make drastic life style changes in order to prevent a second heart attack. Changing a life style is expensive and it takes a lot of time and conscious effort. Meile was not concerned about the money he was losing by not working and was able to put all of his effort towards maintaining a better diet, joining a gym and going to all the recommended follow-up doctors appointments.[20] Wilson was able to take some time off work but the bills from the initial treatments put strain on him and his family to get back to work as soon as possible. Although he was able to make some life changes, the support of a gym, a wife who did not have to work and endless funds of money for a better diet were not benefits Wilson had. Needless to say Gora was the worst off because she had to work more in order to pay her bills. Gora was could not afford to take buses

[20] Ibid. p 33.

to gyms nor could she afford to buy better, healthier food because of her financial burdens. All of the doctors appointments that would have been very helpful in her road to recovery, Gora missed because of needing to work or not thinking it was worth the trek to the hospital.[21] The advice doctors would have given would have likely been to straining financially for Gora to listen to. All three New Yorkers took different paths to recovery because of where they lived, and arguably what social class they belonged to.

Gora was profiled as a poor, immigrant women and instead of trying to give her the same treatment as an upper-class architect, her diagnosis and hospital experience was spotty and ultimately inefficient. This was the result of her own lack of resources (of money, time, support), her lack of knowledge and choices on the part of the hospital to offer her insufficient patient care, education and support. It is not at all surprising that Gora was failed by her class at a hospital that serves some of the poorest people in New York City and is significantly overused because the members of the community don't know where else to go when their health is compromised. Class profiling and behavior came into play in all three of these individuals' experiences. As predicted and expected the best treatment and certainly the most favorable outcome benefitted the most affluent of these individuals. Like the old expression, "Life at the top has its perks," wealthier, more educated individuals receive perks from our health care system and provide advantages to their own care that yield the most effective (and ultimately the most cost effective) outcomes. Nearly all aspects of life, from as early as childhood,

[21] Ibid. p. 34.

throughout schooling and adulthood reflect and reify social class. Social class is evident everywhere and additionally it is reinforced by nearly all decisions an individual and society makes.

Before meeting another individual, before shaking hands, before hearing a word out of your mouth all we have to represent ourselves is our body. Our body is all we have to show our identity before we actually meet someone. So many things can be said about a person simply by looking at their "outer shell" and not knowing a single thing about their life, their past, or future. Vivyan Adair's essay about cycles of individual bodies, social policy and law of bodies, "The Missing Story of Ourselves" explains how quickly bodies are read, produced and patrolled in society. The objective of this essay was to give readers a "first person view of what poverty and resistance through education look[s] like from the inside out."[22] The essay shows how bodies are marked, ridiculed and scrutinized in order to understand a person. After humiliating experiences of being profiled, pitied and distanced from a bus driver and caseworkers at the Department of Health and Human Services, Adair recalls that she realized that humans read other's bodies like texts that thereby concluding that her daughter and herself "pathological and aberrant and in need not of support but of control, regulation, punishment and discipline."[23] The reading of bodies like texts is a way to connect all bodies to dominant ideologies of society. As humans we look for reason, explanation and more importantly categorization for everything and every aspect of life. Bodies are an ideal way to judge, profile and

[22] Adair, Vivyan C. "The Missing Story of Ourselves: Poor Women, Power and the Politics of Feminist Representation". *National Women's Studies Association Journal*. 20, no. 1 (Spring 2008): p. 2
[23] Ibid. p. 2

categorize a person. Bodies are the reason people go to hospitals; therefore, the profiling and judgment that takes place in hospitals must be of a greater magnitude and result in various treatments whether they are medical or attentiveness and attitude of hospital staff.

**Introduction**

Every hospital has a mission statement that claims their hospital will give unprecedented and equal care to their surrounding community. Hospitals in different areas that serve different socio-economic groups have divergent and unequal treatments and outcomes. This summer with the support of a Levitt Grant, I had the opportunity to examine practices and outcomes at a hospital located in a very affluent area, another hospital in a very poor and crime-ridden area, as well as two hospitals in between these extremes. All four hospitals serve different classes of communities. Although the hospitals claim to offer equal treatment, my investigation found that the kind and quality of care given varied greatly depending on the surrounding community of a hospital. I ascertained the social class of patients going into each hospital by researching the demographics of the surrounding community of each hospital.[24] I found that the first "profiling" occurs when and if patients are able to decide what hospital to seek treatment from based on their knowledge of the hospitals, their conditions, and treatments. The second level of profiling occurred in the emergency departments of hospitals based on the

[24] Propensity Ideal Target. Medseek. ePropensity. Birmingham, Alabama. 2012. Online. Accessed 22 May 2012.

surrounding community and therefore the social class and the likely insurance coverage or lack there of. A final level of profiling occurred in terms of the development of treatment plans and patients abilities to follow through on those plans, based again on their class resources, knowledge and supports.

The mission statements of the four hospitals I investigated are below:

St. Francis Hospital of Trenton New Jersey:

> *In the spirit of our founders, St. Vincent de Paul, St. Louise de Marillac, and St. Elizabeth Ann Seton, the Daughters of Charity Health System is committed to serving the sick and the poor. With Jesus Christ as our model, we advance and strengthen the healing mission of the Catholic Church by providing comprehensive, excellent healthcare that is compassionate and attentive to the whole person: body, mind and spirit. We promote healthy families, responsible stewardship of the environment, and a just society through value-based relationships and community-based collaboration.*

University Medical Center of Princeton, New Jersey:

> *The Mission of Princeton HealthCare System is to be the focal point of a comprehensive community health system that responds to the healthcare needs of our service area residents. Princeton HealthCare System will provide inpatient and outpatient care, community health education, medical education and should promote medical and scientific research when appropriate. It is integral to the Mission of Princeton HealthCare System to continually improve*

*quality of service to our patients and community and to provide appropriate healthcare to all.*

CentraState Healthcare System of Freehold, New Jersey:

*To enhance the health and well being of our communities through the compassionate delivery of quality healthcare.*

Robert Wood Johnson University Hospital of Hamilton, New Jersey:

*Robert Wood Johnson University Hospital at Hamilton is committed to "Excellence Through Service and Quality." We exist to promote, preserve, and restore the health of our community.*

Each mission statement reflects the hospitals commitment to serving their communities, despite the fact that each hospital serves a different demographic.. The two most extensive mission statements are from the hospitals that represented the affluent community and the lower income community in my study. There are some distinct differences in the statements, which can be attributed to the fact that their patients conduct very different lives and are a part of very different social classes. The phrase that sticks out the most in the Trenton Hospital's mission statement is, "committed to serving the sick and poor." Most of the patients going to the Trenton Hospital are below the poverty line and therefore their Mission Statement acknowledges this fact. Princeton's Mission Statement talks about educating their community, promoting scientific and medical research and constantly pushing the boundaries to improve their care. I think within the mission

statements of the different hospitals there are clues describing their location and therefore the type of community the hospital will be caring for.

This project began with the goal to access profiling in emergency rooms at a hospital in Princeton and a hospital in Trenton, New Jersey. As my research began and more questions surrounding my topic came up, I ended up looking at the socioeconomic distribution around four different hospitals. Like most things in life, few concepts are black and white. Although I was trying to make Trenton a representation of the lower class and Princeton a representation of the upper class I learned quickly that there are other levels of diversity to explore in terms of social classes and wealth distribution. I set forth this summer to investigate and analyze society's assumptions about the different social classes and the impact these assumptions have on the medicalized bodies of the poor. I wanted to do this by observing Emergency Departments and interviewing doctors, patients and other individuals involved in the health professions. I was very curious to see if the quality of care given to patients who were likely below the poverty line was different, and less extensive than the care given to more affluent and well-supported patients. This seems like a very difficult investigation and because of patient confidentiality laws like HIPAA, which I will elaborate on later, I could not definitively determine the social class of each individual coming into the hospitals. Instead of looking on an individual basis I decided to profile four different hospitals. To be brief, I was proposing the question or idea that an individual's decision to check-in at one Emergency Room in a certain zip-code, versus another Emergency Room located in a different zip code would lead to different types of treatment. To begin with I

sought out evidence of profiling of patients due to the critical decision of what hospital to go to. I then examined aspects of class profiling in emergency room treatment and follow up plans. Because of confidentiality issues I was not able to follow outcomes based on class distinctions, but I feel that they were parallel to those exposed in Scott's New York Times essay.

The Health Insurance Portability and Accountability act of 1996 (HIPAA) provides individuals with guaranteed privacy and confidentiality, thus for my project I needed to find other ways to evaluate the presence of profiling amongst social classes. According to Federal Law, discrimination against individuals on the basis of race, age, gender, physical ability, geographic origin, religion, sexuality, education and economic power is prohibited in hospitals.[25] Although Federal Law prohibits discrimination, there is significant evidence and many studies that prove discrimination is very common amongst hospitals, especially in the Emergency Department. The Emergency Medical Treatment and Active Labor Act, also referred to as the "Patient Anti-Dumping Law" rephrases the concept that no individual can be turned away from an Emergency Department at any hospital. Every individual has the right to an examination and stabilizing treatment without any consideration to an individual's ability to pay or to access insurance.[26] Although these policies and laws allow all individuals to be given care at any hospital, these laws fuel the notion that hospitals in lower-income areas are not giving patients the best care. It is

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[25] US Department of Health and Human Services. *Emergency Preparedness.* http://www.hhs.gov/ocr/civilrights/resources/specialtopics/emergencypr/index.html Accessed Online 16 July 2012.

[26] Resources and Information. EMTALA. http://www.emtala.com/. Accessed 24 May 2012.

assumed that patients going to a hospital in a low-income area are poor and probably unable to pay or to follow up with expensive and time consuming care, therefore it is likely that their care is different than that offered and reinforced to patients who go to hospitals in more affluent areas.

It is clear that hospitals are aware of how the affluence of the surrounding area affects their establishment and practices. An employee at a hospital in Hamilton, New Jersey explained to me that if the new health care system President Obama proposed does not pass through the Supreme Court, it would be devastating for the entire hospital. After further explanation the employee explained that because Hamilton, New Jersey is so close to Trenton, a very poor and broken city, they are constantly giving out "free care" to the hundreds of individuals who walk into the Emergency Department unemployed and uninsured. The health care system has gone so awry that many hospitals are in the same situation as the one in Hamilton. On the other hand, the surrounding community can really benefit from a hospital in our present economy. For example if there is a high population of senior citizens in the surrounding area of a certain hospital, this hospital is receiving payment from Medicaid. Medicaid is a form of insurance coverage for individuals older than 65.[27] Hospitals in middle to low class neighborhoods are facing extreme struggles with too many patients coming into their Emergency department without insurance. Therefore hospitals with a large population of middle class residents, like in Hamilton are not receiving a steady flow of income from government-sponsored programs like Medicaid because the surrounding community is too

[27] Golinker, Lewis. "Medicaid vs. Medicaid: Program Comparison". Assistive Technology Law Center. Ithica, New York. April 2001.

"wealthy" to qualify.[28] At the same time the surrounding community is too "poor" for a large percentage of the citizens to have private insurance and therefore hospitals in middle to lower-middle class neighborhoods are struggling. The question is how do these struggles lead to disparate care for different classes of communities? To begin with it seems that all patients—whether they have insurance or not—are immediately profiled and possibly discriminated against depending on what emergency room they choose or are forced to seek care from.

If there were a few hospitals within a reasonable distance from an individual's house, it would be thought that they would seek care from the "better" hospital. The issue then becomes how one knows what the better or most appropriate hospital is. Is it fair to make a judgment on a hospital's Emergency Department purely on the zip code the hospital has? Or, is it more telling to seek out public records that statistically analyze hospitals? Statistics pertaining to how many errors have occurred and if mortality rates are higher or lower for patients who go to a particular hospital have been available and easily assessable to the general public. Do those who lack education, time, and resources have the ability to do this research, to understand the difference between cutting edge teaching and research hospitals and public service hospitals, between the most effective treatment and patchwork treatment? From a statistical standpoint there have been studies done to see if publicly reporting hospital performances affected the hospitals' market share. Essentially if hospitals had a higher or lower than expected mortality, would these statistics bring more or less business to the hospital? In a medical care study, "The

[28] Propensity Ideal Target. Medseek. ePropensity. Birmingham, Alabama. 2012. Online. Accessed 22 May 2012.

Effect of Publicly Reporting Hospital Performance on Market Share and Risk-adjusted Mortality at High-Mortality Hospitals" done in New York and Cleveland, the researchers identified several hospitals that had mortality rates that were consistently better or worse than expected.[29] All of this data was available to the public, showing these unexpected outcomes; yet, researchers observed that hospitals with higher than expected mortality did not lose market share and hospitals with lower than expected mortality did not gain market share.[30] Researchers speculated changes in market share did not occur because of possible consumer disinterest or difficulty interpreting the reports.[31] This particular study shows a class distinction in education. Education leads to being more informed and therefore life decisions are backed by more solid research and reason rather than instinct and randomness. Class contributes to all aspects of life even when it is not directly applicable in the situation. The study done in New York and Cleveland shows that more education and easier access to information could lead to individuals making better decisions. Unfortunately more education and thus more knowledge of information tend to be dependent on class.

**Demographics**

[29] Baker, David W. et al. "The Effect of Publicly Reporting Hospital Performance on Market Share and Risk-adjusted Mortality at High-Mortality Hospitals". *Medical Care.* V2003 Lippincott Williams & Wilkins, Inc. Volume 21, Number 6, pp 729-740.
[30] Ibid.
[31] Ibid.

To analyze the composition of the communities surrounding each of the four hospitals I initially looked at the crime rate surround the four hospitals. Prime correlates with poverty.[32] The poor are disproportionately represented in prison and in 2010 over half the people incarcerated earned forty percent less annually than the average American.[33] Many theories of class and crime also find a correlation suggesting that individuals resort to crime when the cost or consequences are outweighed by the potential benefits to be gained.[34] The logical extension of this theory is that those with less to loose by incarceration and more to gain by crime, engage in crimes such as burglary and larceny. Investigators expect more crime to occur in poorer areas because of higher rates of material insecurity, need and mental illness. The higher rate of mental illness and the hardships of poverty in general lead to high levels of stress, which translates to a higher rate of crime and other violent acts.[35] I expected the crime to be the worst in Trenton and therefore I suspected crime rate to correlate to hospital admittance levels. I expected hospital admittance to be higher in more violent areas, therefore the areas with the highest crime rate and thus the most poverty. In a 2006 survey Morgan Qutno Awards declared Trenton, New Jersey at the fourteenth most dangerous city

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[32] Williams, Joseph. "Proverty and Crime". McClatchy Newspapers. Capaassociation.org. March 2007. Accessed Online. 10 July 2012.
[33] Criminal Justice USA. "10 Statistics You Should Know About Our Prison System". 17 May 2011. Accessed Online 20 August 2012.
[34] Wright, Paul. "The Crime of Being Poor". *Prison Legal News.* Accessed Online 29 August 2012. www.prisonlegalnews.org.
[35] Taylor, Blake. "Poverty and Crime" 2006. Fundamental Finance. Accessed Online 4 July 2012.

in the country.[36] Trenton is split into five different boroughs, none of which are considered safe after dark. There are many different gangs that the local newspapers consistently report on; for example the "Bloods" and the "Crisps" are the two main gangs. On May 31, 2012 The Davis Law Firm, LLC reported that in the past year there has been a 200 percent increase in burglaries in Trenton's North Ward.[37] The North Ward is likely the most dangerous section in Trenton, although there aren't any areas in Trenton that are considered safe after dark. The increase in crime inevitably causes Trenton to be more susceptible to injuries leading to more people needing to use the Emergency Department. The greater volume in the emergency department results in negative consequences of profiling. Having so much crime in Trenton fuels the stereotypes and profiling in the nearby hospitals causes patients to experience a lower (and ironically more expensive) quality of care.

The high crime in Trenton is contrasted with the very low crime rates in Princeton. By using different search engines to generate models of the crime in a five-mile radius of the town, it became clear that the most crime was in Trenton, following was Hamilton, Freehold and Princeton.[38] By knowing the distribution of crime, a correlation can be suspected between the crime rates and the affluence of the community. Trenton is the poorest of the four locations and therefore this very

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[36] Morgan Quitno. City Crime Rankings by Population Group. Morgan Quitno Awards. 13th Annual America's Safest (and most Dangerous Cities) 2006.
[37] Navani, Sherrina V. "Burglaries up 200 percent in Trenton's "Little Poland". The Trentonian. 31 May 2012.
[38] Crime Rates. Neighborhood Scout. Freehold, Hamilton, Princeton and Trenton, NJ. Location Inc. 2001-2012. http://www.neighborhoodscout.com/search/2947971/. Accessed 14 June 2012.

poor city is filling up the Emergency Rooms of St. Francis Hospital in Trenton with either uninsured patients or patients on Medicaid. In Hamilton the crime is high but not as bad as it is in Trenton therefore it would be expected that fewer people qualify for Medicaid and are just uninsured. This makes the Robert Wood Johnson Hospital in Hamilton much more vulnerable because the Emergency Department is handing out "free care" and the hospital is receiving less revenue in the form of Medicaid payments.

If an individual had the choice between having coverage from Medicaid or private insurance, the first response would be private insurance. Having private insurance says something about your lifestyle: you have a job and are relatively financially stable. The difference between Medicaid and private insurance comes down to the idea of access. If you have private insurance you have access to many more services than those on Medicaid. The reason behind this is simply because physicians are barely reimbursed by Medicaid, whereas they given a much higher reimbursement for private insurance companies.[39] Physicians in private practices are not by any means required to accept Medicaid, and many do not because it is not worth the time and effort for the amount of money they will receive. Therefore hospitals are much more vulnerable to Medicaid patients because they cannot turn anyone down. This is causing emergency rooms to be more crowded in areas where there is a high population of people with Medicaid. Too many patients in an emergency room can never guarantee the most attentive and best care for each

[39] Fine, Bryan R. MD, MPH. Medicaid vs. Private Insurance: Which is Better?" Physicians Practice. 21 November 2011. Accessed Online 13 August 2012.

individual. With this in mind the amount of people on Medicaid can determine the success and quality of a hospital.

In Freehold the crime is significantly less, only the borough of Freehold has a fairly high crime rate.[40] Therefore the Freehold hospital likely profiles their patients to have private health insurance and a minority of people coming in to the Emergency Room with Medicaid or no insurance. Using the most updated and accurate models of the demographic of the four locations there are many conclusions that show how these four hospitals profile patients differently depending on the type of community they are serving. These models depict the socioeconomic distribution as well as other details (such as the percentage of patients on Medicaid and the use of ambulatory urgent care.)

Ambulatory Urgent care, also sometime referred to, as "Doc in a box" are big players in today's health care. An individual may go to an urgent care center instead of the Emergency Room if they are suffering from some illness and they cannot see their primary care physician. This additional component in our health care system provides outpatient care. An example of when these facilities are very poplar is when individuals are seeking care on vacation. One-way to access the community surrounding the hospitals is to see how likely it is that individuals in this community sought out ambulatory urgent care. To continue the vacation example, if an individual has a toothache it is much more economically feasible to go to a "Doc in the Box" rather than at an Emergency Room. Most individuals who are covered by private health insurance know what ambulatory urgent care is and they also

[40] Ibid.

understand the appropriate times to use it. Often it is individuals of low-income backgrounds that don't know these facilities exist or assume these care centers will be much more expensive than taking a trip to the emergency room. Thus it would be expected that low-income areas, around Trenton for example, would have a lower rate of ambulatory urgent care than places in the community surrounding the Princeton Hospital.

After finding and analyzing models reflecting the socioeconomic distribution in the communities surrounding each of the four hospitals I was able to also analyze certain "variables," one of these variables being the use of ambulatory urgent care. The models created by some of the most talented demographers in the nation break down the accessibility and use of ambulatory urgent care by zip code therefore giving insight about the population within each zip code. The city of Trenton covers 27 zip codes although seven of these zip codes represent Hamilton, New Jersey, and the location of the Robert Wood Johnson Hospital. The demographic models give a percentage of the likelihood the people residing in this zip code will use urgent ambulatory care. The higher the percentage, the more affluent the people are and also it is more likely these individuals have health care coverage. After analyzing the demographics of Trenton and Hamilton it was clear that although both locations are not extremely affluent, Trenton is worst off. Three zip codes had percentages of below 50% whereas in Hamilton the lowest percentage in the zip codes that cover Hamilton is 65% although most of the percentages for the zip codes were in the low

eighties or above.[41] The higher percentages overall are found in Hamilton and some of the lowest percentages are found in Trenton, which is expected because the inner city of Trenton is a very poor and crime-ridden area. The overall demographics of Trenton and Hamilton are very similar, the main differences are found in the use of ambulatory urgent care. Freehold and Princeton are two locations that are suspected to be wealthier and thus patients are able to know about and take advantage of ambulatory urgent care. Freehold and Princeton both have higher average household incomes: $65,399 for Freehold and $73,563 for Princeton. The average household income for both Trenton and Hamilton was around $49,000.[42] The difference in average income demonstrates differences in the suspected class distribution in the different areas.

The demographics of the four locations as well as the models that predict different variables allow correlations to be found between classes. By understanding the different classes, as well as characteristics of the populations in each location, assumptions can be made about the typical experiences of members of the communities. Through demographic data and zip code break down information the "average individual" can be created and understood. The concept of the average individual from Trenton, Hamilton, Freehold and Princeton all represent baselines for profiling patients. This image and assumptions surrounding and creating the average individual for each location dictate how the Emergency Department operates and treats patients. Treatment patterns can vary as well as

[41] Propensity Ideal Target. Medseek. ePropensity. Birmingham, Alabama. 2012. Online. Accessed 22 May 2012.
[42] Zip Code and Area. Local Demographics. Zipcodeare.net. Online. Accessed 21 June 2012.

admittance rates and wait times depending on what the stereotypical patient is for the community surrounding the four hospitals.

**Emergency Room Experiences**

Colleen McKee's short story "My Season of the Paper Dress" describes her experience of being sick and poor. The protagonist, Colleen, is a young-adult who is suffering a cough. Financial constraints prevent her from seeing a doctor so she has to go to free clinics. Even though she suffers from a cough, a respiratory issue, each check requires a Pap smear, blood test and HIV test at each appointment. The nurses were extremely unfair and conversed with the woman like she was incredibly inferior. When asked if she had sex with a man or woman Colleen replied, "A woman". Although Colleen initially thought this was a good sign, not assuming she was straight and being open to the possibility of her being gay the nurse continued to probe with questions as if she did not hear the response. For example "Did you use a condom?" "Are you taking birth control pills?" and lastly "Are you trying to get pregnant?"[43] These questions were likely being read off a piece of paper and the nurse was view the patient as an unintelligent and lesser human than herself. There were no signs of care or compassion in this free clinic. When talking with her mother later she as explaining that where they used to live a toxin was being release making many people sick. It took years to actually evacuate

[43] McKee, Colleen. "My Season of Paper Dresses": Tea, Michelle. Without a Net: The Female Experience of Growing up Working Class. Accessed Online. Google Books. p. 104.

people and when Colleen asked her mother why it took so long before the EPA and Department of Health showed us, she responded, "It was just poor people you, know? It was all poor people living out there." [44] Colleen's pursuit for a diagnosis was impossible and an agonizing process. In the end Colleen concludes that the moral of her story is, "If you're poor and from Missouri, Take two of these, drink two tablespoons of that, don't ask questions, don't screw around, and whatever you do, please don't call us in the morning."[45] Colleen was not being viewed as anything but a poor, lower-class woman who was just another body in the clinic. Her body was profiled and because she was seeking help from a free clinic her entire lifestyle was predicted. Colleen was presumed to be dumb, over exaggerating and completely clueless about what was going on with her body. The treatment she received reflects the type of profiling that can occur when an individual walks into a particular emergency room. Depending on the location and the presentation of an individual's body, many people in the hospital will likely presume they know their life before they even open their mouth.

Observations of the Emergency Department in Trenton and in Princeton demonstrated levels of profiling. Pulling up to the hospital in Trenton the sounds of sirens constantly seemed to be very normal. When walking up to the Emergency Department one observes a high black fence surrounding the hospital's campus and about every ten feet there are signs indicating the presence of surveillance cameras. The houses just outside the hospital were very run down. Many individuals were sitting on the stoops of different houses. As a Caucasian and blonde girl it was clear

[44] Ibid. p. 106.
[45] Ibid. p. 108.

that I stood out. Walking by the houses I could feel the eyes of the homeowners and the catcalls were far from discreet. Even though I was about fifteen minutes away from my cow-town home I felt very uncomfortable during my five-minute walks to the hospital. Before getting to the entrance of the hospital, ambulances lined the street. Around six were outside the emergency department daily, waiting for calls. It was not abnormal to see individuals on stretchers inside the rigs waiting to be taken into the hospital. There are police officers and security personal surrounding the perimeter of the hospital, especially near the Emergency Department entrance.

Once an individual enters the Emergency Department they are subject to different security precautions, like a metal detector. The abundance of security showed that there have been dangerous situations in the past and it would not be a surprise if trouble were to arise again. The high level of security demonstrates how the Emergency Department and the hospital in general profile incoming patients to the Emergency Department. A significant amount of security was needed to ensure the safety of the hospital and all the patients and staff inside.

In sharp contrast, once an individual drives into Princeton the wealth and upper class is quite obvious. The town itself is very "preppy," the stores and restaurants surrounding the hospital are very expensive and the houses, on a whole, are absolutely beautiful. Indeed a nurse who works in the new Princeton Hospital referred to the hospital as a "hotel." It is so nice someone might think they are in a hotel rather than a hospital. There is a large reception area that acts as the primary entrance for the hospital. The welcome desk if filled with candy-strippers who look pleasant and friendly. I am sure there is a top-notch security system installed

throughout the hospital but there were not metal detectors or an abundance of security in evidence. The Emergency Department was like the rest of the hospital. It was brand new and looked to be teeming with staff ready to assist any patient who walked through the doors or came in by ambulance. The general feeling and vibe received in the Princeton Hospital was positive. The hospital seemed to have figured out everything, from the best treatment to proper bedside manner, they had taken everything into account.

Simply by driving and walking around the two different hospitals in Trenton and in Princeton the differences were very apparent. The Princeton Hospital seemed safer and from a "customer" or possible patient objective I would not have thought twice in choosing Princeton. Even without knowing the names of the towns I was in, the atmosphere surrounding Princeton Hospital seemed much safer, and more productive with professional staff who were willing, able and indeed eager to put all of their energy and talent towards helping with treatment. The Princeton Health Care system has a strong reputation and therefore is able to pull doctors and nurses into working there. The reputation as well as the location makes it an ideal place to work. While salary reports are not released it was explained that money works depending on the concentration of doctors around. Working for Princeton is prestigious and a job to be proud of therefore this reputation peaks the interest for strong physicians. I am one of three children in my family and when my mother had to choose where to have each of us Princeton was her first choice. She described it as having the best reputation as well as really clean facilities and the best doctors around.

By understanding the surrounding community many more inferences can be drawn about treatment available at different hospitals. Dr. Jeffrey Brenner, a local physician, has been doing conducting similar research about profiling patients by location and their choice of hospital. He has discovered the presence of patterns he calls "hot spots" of disease, crime, injuries and other ailments that can lead to a groundbreaking change in our health care system. Brenner is the founder and executive director of the Camden Coalition of Health Care Providers. Under his command, three health-care groups in Trenton, Camden and Newark are attempting to identify and treat some of the neediest patients while lowering overall medical costs. To do this, their main solution is to form an alliance that Dr. Brenner and many others believe could change the face of health care across New Jersey and the nation.[46]

Dr. Brenner looked to neoconservative literature to discover that a healthier community can be achieved without eliminating poverty. Neoconservative literature about community policy explains that poverty doesn't always have to equate to crime and violence. Better communities, healthier communities can be achieved without completely curing poverty.[47] Dr. Brenner took the neoconservative concept and applied it to his practice of medicine. He has received a lot of recognition for using hospital records to design a model that identifies "high-

[46] Rosenau, Joshua. "Changing face of health care in New Jersey". Trenton Times. 28 May 2012.
[47] Brenner, Jeffery M.D. Interview with Atul Gawande on May 13, 2011. *Doctor Hotspot.* Frontline. PBS. http://www.pbs.org/wgbh/pages/frontline/doctor-hotspot/ Accessed 28 May 2012.

cost hot spots."[48] These high costs are the result of over use of the emergency room. Too much activity in the emergency room results in less than adequate treatment. Many times when the emergency room is being overused there are millions of dollars that are being wasted. According to Brenner's research, use of the emergency room is most common by low-income individuals. As other research has revealed, "Doc in the Box" or ambulatory urgent care is a resource that low-income individuals do not usually recognize. These poorer patients think urgent care is more expensive or they don't know that these urgent care centers exist or what their purpose is. Therefore in poorer communities the emergency room is likely to be overused resulting in wasted money and exponentially increased costs for the health care system.

Low income and often uninsured visitors to the Emergency Room are labeled as "high-utilizers."[49] St. Francis Hospital in Trenton was included in Brenner's research and analysis. One patient in the Trenton area went to the Emergency Room and was admitted more than 450 times, which equated to about a half-a-million dollars in medical costs according to the president of the Trenton Health Team, Christy Stephenson. Stephenson, who is also the vice president for the strategic and clinical transformation for St. Francis explained that many health organizations in Trenton and the surrounding area had to get together to help find a solution for this "high-utilizer."[50] After analyzing the Emergency Room Records hospitals in Trenton, Dr. Brenner and his team found the top 5% of the "high-

[48] Rosenau, Joshua.
[49] Ibid.
[50] Ibid.

utilizers" of the Emergency room represented about 20% of overall hospital costs for utilization.[51] Dr. Brenner has gone beyond identifying this program and has proposed that hospitals and health organizations need to stop competing and form an alliance. He proposes that the only way the health care system will stay intact and under control is if we start promoting preventative medicine and educate all types of people about the medical resources available to them. For example, I believe that through education lower-income families can learn about other health centers that can offer care. Central to the modern day Hippocratic oath—an oath all doctors take before they start practicing—is the credo that physicians will "prevent disease whenever I can, for prevention is preferable to cure."[52] Preventative medicine will help lower the volume of patients in the Emergency departments, especially in low-income areas. An investment in patient education for low-income communities would improve health care delivery and allow us to reduce "high-utilizers" of the Emergency Room. This will not only save the system millions of dollars but it will also clear out the Emergency Department in hospitals so better care can be given to all patients.

Reducing the number of "high-utilizers" could bring down the effects of profiling in Emergency Rooms. To do this Dr. Brenner and his team mapped out areas around the hospitals he was looking at, for example Trenton. He found out what areas were high-cost hot spots. The locations of these hot spots lead researchers to believe the highest concentration of high-utilizers were in these

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[51] Ibid.
[52] Tyson, Peter. The Hippocratic Oath Today. NOVA Online. 3/27/2001. http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html Accessed 2 June 2012.

areas. The mapped out areas in and around St. Francis Medical Center in Trenton showed that the hot spots, showing high-cost areas were "smoldering" around the Rescue Mission of Trenton and the Trenton Area Soup Kitchen.[53] This shows that in impoverished areas, individuals who have to use the soup kitchen and rescue center for survival are the individuals who are costing the health care system so much money. Many doctors, including Dr. Brenner believe this is not because low-income patients have much more complicated sicknesses but because they are not receiving the same quality of treatment from the local hospitals because of the negative consequences of profiling.

**Emergency Room Profiling**

Profiling occurs from both sides; not only do hospitals profile patients but patients also profile hospitals when they are making a decision on where to go. Dartmouth Medical School has conducted many studies pertaining to the access of physicians and the affect public records about hospitals has on surrounding communities.[54] Many researchers have tried to find a correlation between geography and the quality of care available. The claim is that patients in geographic areas that are poor or have less accessibility to physicians will likely receive a lower quality of care.

[53] Ibid.
[54] Fisher, Elliott S. et. al. "Health Care Quality, Geographic Variations and the Challenge of Supply-Sensitive Care". Johns Hopkins University Press. Perspectives in Biology and Medicine Vol. 55, no. 2. Spring 2012.

Observations in Emergency Rooms for this study reveal the practice and impact of class profiling. The location of a hospital influences the treatment a patient will receive, not solely because of societies' stereotypes but also because of profiling the health care system encourages. Doctors are not treating patients of different social classes the same, this can likely be attributed to profiling, a large part of the profiling has been forced upon doctors because of flaws and new protocols in the health care system. When an individual completes medical school and passes the final examination they are inculcated with the "Hippocratic Ethic." In short, this tradition requires all doctors to use the best of their knowledge to recommend to patients the treatment that is in their best interest.[55] The health care system as it is today has made a new imperative necessary; that of prescribing treatment that is appropriate to the fiscal health of the medical institution. In a 2012 essay Dr. Jeffrey Singer calls this imperative a "veterinary ethic," wherein the interests of the "payer" are placed ahead of those of the patients.[56] Treatments are given along with prices because only certain treatments are available to the poor, whereas the affluent population can afford cutting edge technology giving them a better chance at a full recovery. If an individual is poor they are only going to be presented certain treatments because they cannot afford anything else. Therefore no longer can doctors recommend what is best for the patient, but what is best for the patient given their budget. This ethic determines practices and outcomes in Emergency rooms of different classes.

[55] Dr. Singer, Jeffrey A. Notable & Quotable. Reason.com. March 15, 2012.
[56] Ibid.

When a young man came into a hospital in Trenton he looked homeless and deathly ill. He complained of headaches and pretty much every other type of ache in his body. There was not any family with him and the doctors figured his lifestyle would lead to this middle-aged man having some much pain. Additionally being admitted into a hospital at least gave him a nice place to sleep and food. After passing him off with having a severe case of the flu they did not take precautionary tests. This man ended up having a problem with his spinal cord leaking thereby causing immense pain. Although he may have had the flu he definitely had something else going on. Because his diagnosis was not pursued further to see if there was something else going on this man nearly died. The scans and tests to see what was going on before the man flat-lined from his injury, although expensive would have ended up causing the health care system much less money. The emergency surgery for many hours could have been prevented had the body and lifestyle of this man hadn't been profiled and judged so harshly.

This example can also be reversed completely. When a family member went to the doctor for a routine check-up something much more serious was discovered. She was having a heart attack while in the doctor's office and thought it was only severe heartburn. Because she had the luxury of being able to see a doctor for routine checkups she could be helped nearly immediately and her recovery time was very short. Although it cost money to have these routine checkups and have insurances, she did not cost the insurance company nearly as much because she was able to get immediate help and the proper test done because she had a primary physician. Primary physicians are significant players in the health care system

because they can keep patients informed with their health before catastrophe strikes or before a illness builds up to the point of needing hospitalization.

While it is terrible think the "payer" comes before the "patient" this logic to save the health care system money might be completely wrong. Putting more money into concepts like preventative medicine may prove to reduce emergent procedures and emergent treatment. A very wealthy lawyer goes to the Princeton Hospital with chest pains and instead of being given some anti-acid or heart burn medication he is going to be given the best tests available. His two thousand dollar suit and polished shows scream upper class and prosperous. The hospital staff knows immediately he has money because of how he has presented his body and therefore he will be given quick, effective treatment. Instead of being asked to wait it out and see if the pains calm down after some over-the-counter medication he will be given the blood tests, scans and other precautionary measures to rule out all anything else that could be causing his heartburn. The fluctuation in treatment depending on what hospital people enter and how they present their body is incredible. The Board of Health wants to save money and cut costs and therefore it is recommended that tests are not done unless absolutely necessary. Exceptions are not supposed to be made but it seems ignorant to think that the homeless man and successful lawyer will be given the same choices when it comes to their treatment and the care they want for their bodies.

Another factor that could effect the profiling that occurs in hospitals is the quality of doctors at hospitals in different locations. When talking to my primary physician I told her about the research I was conducting. She thought it was very

intriguing and began depicting the road of becoming a doctor. For residency an individual can be placed essentially in any hospital in the United States. Recommendations are in consideration but for the most part an individual will finish their four years of medical school and then continue a minimum of four years of residency at whatever hospital they are assigned to. After residency doctors tend to have chosen their specialty, for example Emergency Room doctors, oncologists, pediatricians. At this stage doctors begin their "job search" and go work in a hospital or group practice of their choosing. My physician explained that if her group practice keeps their patients admittance rates to hospitals low and for the most part keeps their patients healthy they are likely to receive more money. Therefore the location where a doctor practices affects how well they are paid.[57] A healthier community leads to more money for the doctors. This lead me to think that as a doctor I would want to work for a group located in an area that would likely give me the healthiest group of patients.

If better doctors migrate towards more stable and affluent hospitals then this pattern is feeding the social class system of society because it continues to repress the lower-income families. Lower-income families might not have as strong of a network of doctors near them therefore their care might not be of the same caliber of wealthier families. The wealthier families will receive the best care keeping them healthier and therefore they are able to live their lives with more opportunity and more than likely, more success.

[57] *Physicians Salaries: Pediatrics Salaries*. MomMD, LLC, 2012. http://www.mommd.com/pediatric-salary.shtml Accessed 31 May 2012.

Of course everybody can get sick, get cancer or get into some type of accident. Yet, there are differences in the likelihoods of health between the social classes. Preventative medicine brings disease and sickness rates down. Preventative medicine is not a well-understood concept for many people, especially individuals of lower-income families. For example in terms of pediatric care, higher income families are more likely to consist of two parents, and therefore be able (because they have the time and resources) to be more attentive and aware of the medications that their child should take when they have common sicknesses like a cold, or ear infection. In lower-income families the children are more likely to have more responsibility and the families may not be as aware of the medications that their children should take, or how to properly avoid getting sick, for example taking vitamins, eating balance meals and using proper hygienic techniques, i.e. hand-washing before eating. Preventative medicine is what many physicians claim is the key to a healthier community. Dr. Brenner, mentioned above, preached this message when he was proposing solutions to improving the health in areas like Trenton, New Jersey.[58] With this in mind, it becomes clear that it is expected that doctors want to work in healthy areas to they can earn more money, therefore the best—the most sought after—physicians are likely to seek out middle to upper class locations. Low-income patients are likely to have more health problems and thus will need to be admitted to hospitals more. These doctors, who tend to communities with more health problems, are going to have fewer resources available to them because of the financial restraints of the community. Although they might be

[58] Rosenau, Joshua

fantastic doctors, statistically they will not look as strong as doctors who are working with healthier, and thus likely more affluent communities.

Doctors in hospitals located in lower income areas will have a greater influx of patients who are less likely to take care of themselves because they can't afford it. This can lead to a different approach in treatment and overall the fewer resources doctors have available in less affluent areas results in a lower grade of care. Not only does the surrounding community affect the profiling that occurs in emergency rooms, but also the quality of care doctors can give is dictated by location. A lower income community will not be as likely to follow preventative measures to avoid sicknesses and diseases and thus more people will need to be admitted to hospitals. Lower income families can't afford extensive treatments thus hospitals are not earning a lot of money even though there are a lot of patients. With less money, the hospitals cannot afford the top of the line technology and the income of doctors will be different from doctors in affluent locations. It is not only the community that causes profiling but the poorer areas will have doctors who cannot diagnose and treat patients the same way; not necessarily because of the intelligence of the doctors but because of the lack of resources available.

Recent research by Dartmouth Medical School illustrates that when patients go to the emergency department the doctor-patient relationship can give vast insight on the quality of care the individual will receive. Dartmouth found that geographic variation demonstrate gaps in the quality of care but also shows an extremely strong, and previously unrecognized relationship between capacity available in a certain area to treat patients and quality of care that is given in this

area. Essentially different geographies around our nation are home to many different types of people. Although there are some similarities within certain "types" of geographies the diversity in terms of race, social class and intellect level are different everywhere. The poor economy the past few years has led to higher unemployment. Beyond this, many individuals who did not lose their job were likely to lose a lot if not all of their health coverage that was previously provided by their provider. These factors have led to the percentage of Americans with no health insurance to continue to rise. In January Gallup reported that in 2010, 16.8 percent of Americans did not have health insurance[59], now figures from Gallup-Healthway Well-Being Index showed that as of December 2011 the percentage of uninsured people in America 18 and older was up to 17.7 percent.[60] These factors have resulted in academics rethinking the power of a doctor-patient relationship and how patients profile their doctors and their hospitals.

The Dartmouth Medical School examined many other patterns, in addition to the reverse profiling; investigations were done on the correlation between high-cost and low-cost regions on patient outcomes. The Dartmouth Atlas data was used to group 306 hospitals into deciles based on average sex, age and annual spending and found that high-cost hospitals treated patients differently. High-cost hospitals do not refer to the affluence of the hospital, but how much the hospital ends up

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[59] Young. Jeffery. "Number of Uninsured in U.S. Rises as Workers Lose Jobs and Health Insurance". Huffington Post. 14 February 2012. http://www.huffingtonpost.com/2012/02/14/number-of-uninsured-in-us_n_1276189.html Accessed 14 June 2012

[60] Walker, John. "Number of Uninsured Americans Steadily Increasing". FDL Action. 24 January 2012. http://fdlaction.firedoglake.com/2012/01/24/number-of-uninsured-americans-steadily-increasing/ Accessed 14 June 2012.

spending taking into account the surrounding community and geography. High-cost regions were found to have a substantially higher frequency of physician services as well as higher rates of diagnostic tests.[61] The most aggressive pattern pertained to the intervention in the final months before death. For example, high-cost regions were more likely to be intubated or given a feeding tube instead of letting the patient naturally pass.[62] This could be a sign of doctors not informing their patients of all their options and only "doing their job" by keeping the patient alive no matter the pain or quality of life. There are certainly other factors that can contribute to the fact that high-cost regions go to greater extents to keep patients alive at the very end of life, but one reasonable explanation does tie to the profiling of the surrounding community and the expected affluence and intellect of patients.

After volunteering for a local EMT and First Responder squad I learned that although the squad tries to listen to the patients request sometimes the closest hospital is the only option. Allentown, New Jersey is in relatively close proximity to the four hospitals I have researched. Many times patients have an idea of what hospital they want to go to when they are picked up. If the injury or illness is less severe the squad will always try to listen and follow-through with the patients request. Although there are certainty instances where the patients injury or illness cannot wait and the squad needs to take this individual to the closest hospital. The Allentown EMT and First Response team serves a relatively large area. The socioeconomic models I used for my investigation showed that overall the

[61] Fisher, Elliott S. et. al. "Health Care Quality, Geographic Variations and the Challenge of Supply-Sensitive Care". Johns Hopkins University Press. Perspectives in Biology and Medicine Vol. 55, no. 2. Spring 2012.
[62] Ibid.

surrounding community consisted of individuals of similar financial incomes. Most individuals of the Allenton and Upper Freehold community are a part of the middle class. Depending on where the ambulance is picking up the patient, the individual can end up being admitted at the hospital in Princeton or the hospital in Trenton. These two hospitals represent the two extremes for my investigation. Being taken to the hospital in Trenton will likely result in a very different treatment plan than the individual would receive in the Princeton hospital because of profiling by ER doctors and because of the significant difference in the financial situations of the two hospitals.

One EMT has been a part of the Allentown squad for nearly forty years and she claims that although treatment plans vary in different hospitals, EMTs attempt to remove all profiling and judging from their procedures and care. When picking up an individual the First Responders can make many judgments about the individual from the appearance of their house and their house's location. No matter what the house or neighborhood looks like EMTs have a very strict protocol to follow. After taking a CPR/First Aid and AED class I was qualified to go on "runs" with the local EMT squad. I observed that it did not matter if we were at a very large and expensive house, or a trailer home the questions the EMT's asked were the same. All the patients were treated the same way. The patient was asked a series of questions to ensure they did not have spinal injuries, other family members or friends were asked about a possible accident that could have occurred and the vitals of every patient were taken. Every case is different but the protocol the Allentown EMT's followed was exactly the same. After talking to some of the EMT's about

these observations, one of them explained that although the scene may have something to do with the injury or illness of the patient, their job was first and foremost to stabilize the patient and get them to a hospital alive; any additional information they could retain would only be used to provide the individual with better care.

While EMTs have a very strict protocol to follow, once the gurney is wheeled into the hospitals the EMTs are completely removed from the case and it is up to the doctors of the Emergency Room to treat the patient. Whether the individuals are walking into the Emergency Department to be treated or being brought in by an ambulance, there is profiling that occurs by all staff at all hospitals. Several EMTs of the Allentown squad explained to me that because of the HIPPA laws (explained above) they are never able to find out the outcomes of the individuals they bring into the hospitals. Therefore the EMTs never know if the decisions they made helped or hurt the individual in the long run. All the power is in the hands of the hospitals and the ER staff. All the information collected by the EMTs is handed over to the hospitals and with this information the hospital staff makes certain assumptions and judges the patient to determine a treatment plan. For example the EMTs in one day can pick up a patient from a trailer home who is very poor and uninsured and if the individual is taken to the hospital in Princeton they will likely receive better treatment than if they went to a hospital in Trenton. Even though the individual is poor and uninsured the EMTs ultimately determine what type of profiling the individual might experience by bringing them to a particular hospital. Even though the EMTs strive to treat every patient according to protocol, once they

drop off the individual at a hospital they can no longer control how the patient is judged or profiled by the Emergency Department.

**Hospital Grading System**

Recent studies have tried to find correlations between high-spending hospitals and quality of care. In one study representing 1,255 hospitals showed that hospitals that were considered more "wired" and high-tech were able to provide their patients with better care. A local example found of this idea was with the Princeton Hospital. The new hospital has a more advance system for electronic records that give greater accuracy and speed. The Princeton HealthCare System CEO Barry Rabner credited this new technology to making the hospital rise above local competitors.[63] This correlation needs to be taken with a grain of salt; Alden Solovy, the executive editor of Hospitals and Health Networks explained there are other variables[64] at work that are central. As many researchers have explained there are so many factors that go into quality of care of patients. This study shows that hospitals with better technology are resource-rich hospitals able to employ the best doctors, staff and buy the best equipment. All of these factors are likely the result of patients receiving the best care. This leads to many more questions, and one particularly important conclusion: well informed individuals understand that hospitals in more affluent areas are likely able to provide better care.

[63] Rosenau, Joshua. "Princeton tops' groups hospital list". Trenton Times. 31 May 2012.

[64] Gilbert, Alorie. "High-tech hospitals better at keeping patients alive?" CNET News. 12 July 2005.

Within the past few weeks local reports have been writing articles about the new hospital in Princeton and how it has been given higher "grades" in all categories than the surrounding hospitals.[65] Rating hospitals is a much more complex process than ranking hospitals by the lowest mortality rate. There are many multi-leveled models that researches use that takes into account many different types of bias. Many statisticians devout their careers to creating complex equations and logarithms to "accurately" rank hospitals. While this seems productive and helpful at the end of the day the general public is not going to look up these complexities or understand the truth behind "true" rankings. Instead most people are going to read their local paper like the Trenton Times and see Princeton was given an A and none of the competing hospitals were given a grade higher than a B. The convenience of the local paper allows people to form opinions about concepts like hospital profiling. If the health care system wants to provide accurate accounts of different hospitals strengths and weaknesses, the data about the different variables in hospitals needs to be provided in a more accessible and comprehendible way. More accessible information will allow people from various class backgrounds to formulate more educated opinions.

**Medicaid Coverage and Class Profiling**

By investigating profiling in American hospitals it is apparent the health care system in the United States emphasizes—and indeed reinforces—class hierarchy

[65] Rosenau, Joshua. "Princeton tops' groups hospital list".

amongst members of its community. By law, no one can be turned down by any Emergency Department of any hospital; this does not mean that every individual is treated with the same quality of care or experiences equality in terms of outcome.

Medicaid is a government sponsored insurance plan that covers the very poor. The amount of poverty in Trenton correlates to a high amount of patrons being covered by Medicaid. When John was suffering from a gunshot wound he was taken to the Emergency Department in Trenton. The fact that he had a "violent" injury of a gunshot wound and was going to a hospital in Trenton he was likely profiled to be a member of the very poor surrounding community. He was rushed into the Operation Room and was saved after a grueling number of hours of surgery. John was saved and the hundreds of thousands of dollars he cost the hospital to get this procedure were covered by Medicaid. John, who was suspected to be a drug dealer and criminal was saved and did not have to bear the burden of medical bills because he was poor enough to be covered by Medicaid. John was saved and the argument becomes why was he saved and escaped all medical bill burdens? It can be argued that his impact on society was negative and he shouldn't have a "free pass" after receiving extensive surgery to remove a bullet.

Little Timmy, suffering from epilepsy has parents who are not wealthy enough to afford insurance and yet are not poor enough to be covered by Medicaid. Timmy and his family are going to become bankrupt with all of their medical bills and therefore odds are Timmy will not be able to see the best doctors and receive the best treatment possible to cure him. When Timmy is rushed to the Emergency Department for the third time that month his parents know that the medical bills

are to point of unbearable. The family had to sell their house and move in with relatives. The extreme medical bills make it nearly impossible for Timmy to see a specialist because the family simply cannot afford it. Despite the fundraisers, family assistance, the medical bills are too much. Timmy will continue to be brought to Emergency Departments each time his parents can't control his seizures, but it is likely they will not be able to eliminate his problem. Timmy's parents make an honest living but it is not enough for insurance and they cannot stop working and hope to eventually be qualified for Medicaid, therefore they represent the American citizens who are caught in an extremely difficult position. There is no way out. The American health system is reifying and reflecting the class hierarchy in the United States. Timmy and his family are classified as the "working poor" and there are hardly any options for them to make their situation better.

When I was in high school I was rushed to the Emergency Department because I had a rapid heart beat that I could not control. I went to the hospital in Hamilton because my parents and I were scared and we just wanted to get to the closest hospital. My parents drove me because we did not want to wait for an ambulance. When I arrived at the hospital my mom filled out paperwork while I waited. My heart was still racing but I had to wait for my name to be called. Once called, I was rushed to a bed and hooked up to what seemed like a hundred monitors. My heart was stopped and restarted in order to regain a normal rhythm. It all happened so quickly and before I started to breath normally our insurance information was being taken. At the time I did not think much of this but after this research I realized that at the end of the day every hospital is a business

establishment. In order for hospitals to run they need to be paid. The bills for my visit to the emergency room were astronomical. I was covered by insurance but the deductible was still a hefty price. I am very lucky to be an insured American therefore when I visit a hospital both the hospital and my family can rest easy knowing the exchange of money was made, and it did not haunt my parents at night.

**Policy Recommendation**

Going to the emergency room is necessary on occasion and patients need to feel like they can seek out care in the emergency room and it will know break their bank and it will be the best treatment available. Patients are profiled on whether or not they can pay and depending on what hospital they are going to with what type of emergency. Profiling is a part of human nature but it needs to stop affecting the "business" aspect of hospitals. In order for hospital to provide the best care, care needs to be affordable; although, affordable care cannot entail docking the salaries of the hard working doctors and other hospital staff. Today, for some American the emergency room is a savior; it provides excellent care and insurance allows the care to be feasible. For other Americans the Emergency Room is a nightmare, after long waits care is finally given and within no time insurance information is being taken. Without insurance and without Medicaid the Emergency Depart profiles to a stronger degree and the bills read extraordinary large numbers.

Medicaid and Medicaid are excellent ideas to help protect individuals significantly under the poverty line and the senior citizen; although, the middle class

is very vulnerable with our present health care system. This project has demonstrated that class determines treatment and the surrounding community of a hospital helps dictate the type of treatments available. As unemployment continues to stay high or gets higher more people will become uninsured. Even if they are still employed many bosses are forced to stop giving their employees health insurance because of the present economy. As the number of uninsured rises, which is will amongst the middle class, the quality of hospitals that are among these unemployed areas are going to suffer. There is a growing percent of individuals who do not qualify for Medicaid and cannot afford insurance. Most of these individuals are from different sectors in the middle class. The hospital in Trenton has the poorest community and therefore has many restrictions in terms of treatment that can be offered. Although the hospital in Hamilton, with a less affluent community than Freehold and Princeton is probably the most vulnerable with the present economy and health care system.

This research showed that the profiling in the Emergency Room correlates to the type of community a hospital serves. The over-use of the Emergency Department for non-emergent cases is more common in poorer communities. The poorer the community the higher likelihood that these individuals are on Medicaid, therefore hospitals in Trenton are not handing out 100 percent free care. These hospitals are receiving money from Medicaid. Hospitals in areas like Hamilton are in the most danger. These hospitals have a poor population that don't yet qualify for Medicaid therefore they are handing out the most free treatment in their Emergency Department. This results in more profiling to figure out what individuals are

"priority", or "actual emergency cases" and which individuals are using the Emergency Department for a simple strep test which can be done at an ambulatory emergent center or a CVS for about twenty dollars.

## Conclusions

It is very difficult to draw strong, concrete conclusions to this analysis because of the complexity and multiplicity of the problems involved with our current health care system. I have found that many variables contribute to profiling in Emergency Departments. Two crucial factors that have strong patterns are the community surrounding a hospital and the location of the hospital. The community around a hospital can say so much about what types of treatment are most needed and how people are paying for their frequent or infrequent trips to the Emergency Room.

I am forced to believe that the percent of our population that are deemed the "working poor" need to find a way to be insured. The working poor is the term that describes individuals who are working but are not insured and are not poor enough to receive Medicaid. If the working poor population is reduced then hospitals will not be forced to give out as much free treatment through the Emergency Department. The nation is in desperate need of a health care reform but it is important there are enough doctors to handle the population. As of now there are only enough doctors to care for the insured, and as previously mentioned there is a significant part of our population that is uninsured. With a health care reform there

needs to be more doctors so the population can receive primary care and not rely on Emergency Departments. The more reliance there is on Emergency Departments for non-emergent situations, the weaker the hospital becomes, the more profiling occurs and therefore everyone's quality of care is hindered. Having enough doctors is crucial, but with this the health care reform needs to compensate doctors well enough so it is still worth it for individuals to attend four years of medical school and at least a four-year residency.

In order to minimize the unreimbursed care being handed out by Emergency Departments the percentage of working poor individuals needs to be reduced significantly. To do this a health care reform could enforce all individuals buying health care. This can only be successful with more doctors and proper compensation for doctors. Additionally it needs to be economically feasible if everyone is going to be forced to get health care. One way to do this is through exchanges. Instead of employers providing their employees with health insurance they can give them a certain amount of money to be taken to an exchange. The employees can then exchange this money for health care coverage and their employer will pay the tax on their plan. This will allow everyone to get insurance, even the working poor. Although, the working poor will want to get a very cheap plan therefore will get coverage that involves very high deductibles. This will prevent them getting primary care and only being properly covered for emergent situations. Exchange programs will allow the working poor to seek care for emergency situations and it will not be free care. The main hole in this solution is

that the coverage the working poor will be receiving still prevents primary care coverage.

On Thursday, June 28, 2012 the Patient Protection and Affordable Care Act, informally referred to as "Obamacare" was passed by the Supreme Court. The passing of Obamacare poses a monumental change to the health care system in the United States. This law seeks to give insurance coverage to the 30 million uninsured American citizens. All Americans not insured by employers or government-sponsored plans will be required to be covered by minimal plans to maintain the minimal essential health insurance coverage. It is predicted this act will lead to lower Medicaid spending and slow health care cost inflation thus reducing the national deficit.[66] The research over the past ten weeks proved to me that Obamacare needed to past in order for hospitals like Robert Wood Johnson in Hamilton to survive. Too many hospitals were giving out free treatment therefore this act will require all citizens to have some type of insurance plan to pay hospitals for treatments. Obamacare is a promising step for America's health care system. Profiling in hospitals is present today, and the extent to which it occurs as well as the implications is determined by the demography. After ten weeks of research and the passing of Obamacare it is hopeful that the hospitals like Robert Wood Johnson in Hamilton will feel more assured by this new act because free treatment will decrease as all American citizens become covered by some type of insurance plan.

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