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## Health Care Disparities in Racial and Ethnic Minority Populations

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Health care disparities occur when racial and ethnic minority populations receive lower quality health care and have worse health outcomes than other population groups. Differences in care based on medical or biological factors or patients' preferences are understandable and acceptable, but differences in outcomes not related to considerations of this kind may be problematic.<sup>1</sup> Some disparities in the way we provide care to patients might arise from correctable physician-related factors. Because we are committed to serve our patients equally regardless of medically irrelevant personal characteristics, such disparities present a challenge.

Comprehensive reports from both the Agency for Health Care Research and Quality (AHRQ)<sup>2</sup> and the Institute of Medicine (IOM)<sup>3</sup> found substantial differences in the care received by minority patients. These differences persisted after the data were adjusted for insurance coverage and access to health care. African-Americans have a higher mortality rate than whites from cardiovascular disease, for example, but have fewer cardiac catheterizations and coronary artery bypass surgeries.<sup>4</sup> Similarly, fewer African-Americans than whites with end-stage kidney disease are referred for transplant evaluation, placed on a waiting list, or transplanted, after adjusting for socio-

economic status.<sup>5</sup> Hispanic patients are less likely than non-minority patients to receive appropriate cholesterol management, standard pharmacotherapy after acute cardiovascular events, or cardiovascular procedures.<sup>6</sup> The AHRQ report estimated that Hispanics and American Indians fared worse than non-minorities on about a third of the quality measures they examined, while African-Americans fared worse on about two-thirds of those measures.<sup>2</sup>

Medically irrelevant personal characteristics may contribute to health care disparities, such as cultural factors, racial or ethnic stereotyping, and mistrust of the health care system. Culture contributes to health literacy, and health literacy affects clinical interactions substantially, even more than the well-known effect of racial concordance between patients and their physicians.<sup>7</sup> The use of traditional remedies associated with cultural background can undermine or otherwise interfere with modern scientifically based care.

Physicians consider a wide variety of factors when evaluating their patients; for example, some demographic characteristics, such as age or geographic location, may be relevant to certain risks. However, relying on the demographic characteristics of ethnicity and race to serve as proxies for socioeconomic status rather than determining such status directly from individual information can be misleading.<sup>8</sup> Inappropriate use of superficial traits—stereotyping—may negatively influence physicians' evaluations of patients and consequent treatment recommendations.<sup>9</sup> In this way, the

individualized care that we value for its importance to the healing process may be compromised or lost. The value of racial and ethnic variables in the clinical decision-making process is very limited, and physicians should remain aware of that fact.

Many African-Americans do not trust physicians and the health care system for a variety of reasons. Memory of the Tuskegee Syphilis Study is still fresh in the minds of many black Americans.<sup>10</sup> That experiment was designed to document the natural history of syphilis, and continued from 1932 to 1972. The subjects of the study were poor blacks from the Tuskegee, Alabama area. They were not told they were part of an experiment, did not consent to participating, and, when penicillin became available in the 1940s, infected subjects were not treated. This episode was widely published and discussed, and was in large measure responsible for the development of stringent federal guidelines for the conduct of human research in the 1970s and 1980s. It greatly increased the level of mistrust of the health care system among black Americans.

A more recent example of a cause of mistrust is the subject of this essay: contemporary differences in health care and in outcomes between African-Americans and others. These disparities are well known within the black community, and are another reason for members of that community, in their views, not to trust the health care system and physicians. Our ethical obligation, as physicians, is to provide the best care we can under any given set of circumstances, regardless of

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medically irrelevant personal characteristics. In striving to achieve that goal, we can help to reduce health care disparities. First, we must recognize that health care disparities undeniably exist, and must learn to recognize their causes.<sup>11</sup> We must appreciate the cultural or ethnic characteristics that both affect the health care beliefs of our patients and produce variations in patients' abilities to process medical information. We must be aware of the insidious undermining of good clinical care that can occur when race or ethnicity is used as a proxy for educational or socioeconomic levels or for the capacity to understand medical information. Potential biases are often subtle, so all of us should candidly evaluate ourselves to identify unwarranted assumptions that are based on racial or ethnic characteristics.

Physicians can help in other ways to reduce health care disparities. Good communication based on understanding of patients' cultural or religious beliefs and their levels of health literacy can promote participatory decision making. This kind of decision making best meets the needs and preferences of individual patients and can promote patients' trust.<sup>12</sup> This will eventually pay handsome dividends in quality of care.

Minority physicians are more likely to practice in minority communities and may provide better care for minority patients than other physicians, in part because of greater cultural awareness and sensitivity. Yet, although about 25% of the U.S. population comprises minorities such as African-Americans, Hispanics and American Indians, fewer than 6% of U.S. physicians come from those minority populations.<sup>13</sup> For these reasons, individual physicians and the medical profession as a whole should do what we can to encourage well-qualified minority students to enter the health care professions.<sup>14</sup>

Many physicians are unaware of health

care disparities despite volumes of objective information documenting their existence and causes. Many are aware of the facts, but believe, incorrectly, that all of the differences are due to biological factors. Others are aware of the facts and know that medically unjustified assumptions may contribute to health care disparities, but believe that the care provided by other physicians may be compromised, not theirs. All physicians who treat racial and ethnic minority patients may inadvertently allow subtle assumptions and the consequent erroneous conclusions to influence their care of patients. Whether or not the physician has such biases, they may be present in office staff or others with whom the physician works closely and whose behavior the physician is in a position to modify. In order to provide the best care we can for every patient, we must remove medically unjustified differences in the ways we relate to patients from our practices by accepting the reality of health care disparities and seeking possible contributory causes in ourselves and in our staffs.

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