Racial/ethnic disparities in medical care

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Engaging physicians in the dialogue

Last year, the Institute of Medicine (IOM) released the report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, which concluded, based on an extensive review of the literature, that racial and ethnic disparities in patient care occur among similarly insured groups.[1] One study of Medicare beneficiaries, for example, found that black patients with early stage lung cancer were nearly half as likely as whites to undergo surgery and had lower five-year survival rates.[2] Another study found that Latino patients who had undergone diagnostic angiography were 40% less likely than whites to undergo coronary bypass surgery.[3] A study that identified patients considered appropriate candidates for renal transplantation found that the procedure occurred among 17% of black patients and 52% of white patients.[4] While the evidence varies for specific conditions and racial/ethnic minority groups, the data sufficiently compel us to begin undertaking actions to systematically and aggressively eliminate disparities in needed medical care.

This issue is not new but seldom gets the attention it deserves, perhaps because the public is not well informed that a problem exists. A 1999 nationwide survey found that the majority of Americans—including many minority Americans—were generally unaware of racial/ethnic differentials in health care.[5] They were even unaware of racial differences in health, such as infant mortality and life expectancy, which have been widely reported for many years.

Physicians also appear to have similar misperceptions. Based on a 2001 national survey of physicians, about two thirds of physicians are aware that racial/ethnic disparities exist in specialty services, such as for heart disease and HIV, but they do not believe this is a widespread problem. Less than a third (29%) of physicians believe that the health care system at least sometimes treats people unfairly because of their racial or ethnic background.[6]

It has been suggested that physicians question the quality of the evidence on disparities in care, believing that patient characteristics (eg, socioeconomic factors and disease severity) explain why whites are more likely than others to receive some medical treatments.[7] With the IOM's conclusion that racial/ethnic disparities in medical care exist even among individuals with similar health care access, the time has come for physicians to become more engaged in this issue.

In many ways, physicians are in an excellent position to impact the mix of patient, clinician, and health system factors that contribute to disparities in medical care. They are on the front lines of the health care system and are major decision makers in health care. Some of the factors thought to contribute to racial/ethnic differences in patient care may be beyond the scope of physician influence, such as the benefits available through a particular health insurance plan or the availability of high-tech equipment in hospitals used most often by racial/ethnic minority groups. The physician does exercise control, however, over other factors such as patient-physician communication and biases in the diagnostic and referral processes.

Given that treatment for heart disease looms large as an area where physician intervention can make a difference, it is especially important for physicians to be engaged in efforts to address racial and ethnic disparities in cardiac care. A report produced by the Henry J Kaiser Family Foundation (KFF) and the American College of Cardiology Foundation (ACCF) concluded, as did the IOM, that there is credible evidence that minority patients are less likely than white patients to receive invasive cardiac procedures, including cardiac catheterization, angioplasty, bypass surgery, and thrombolytic therapy.[8] These disparities remain even after adjustment for such factors as age, sex, insurance status, and heart disease severity. Of the 81 studies investigating racial/ethnic differences in cardiac care over the past two decades, 68 found disparities in care for at least one of the racial/ethnic minority groups under study.

It is time for the medical community to become more actively engaged in efforts to understand

why treatment differentials occur and how to address them. An initiative undertaken by KFF and the Robert Wood Johnson Foundation attempts to raise physician awareness about disparities in medical care, beginning with cardiac care (http://www.kff.org/whythedifference). Three major heart organizations—the ACCF, the American Heart Association, and the Association of Black Cardiologists—are partners in this initiative, which is cosponsored by 10 additional national medical, public health, and business organizations (including the American Academy of Family Physicians and the American College of Physicians/American Society of Internal Medicine). The initiative has included an ad campaign in major medical publications and outreach efforts encouraging physicians to review the evidence on this issue (see advertisement on p 324). By supporting this initiative, leading medical organizations are making a public statement that racial/ethnic disparities in treatment are a real problem.

Only when physicians are engaged in this issue, become familiar with the evidence, and assess their role in eliminating disparities in care will the nation make progress in ensuring that all patients are treated equally, regardless of their race or ethnicity.

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Treatment of raised intraocular pressure and prevention of glaucoma

Evidence at last that treatment works

Two important randomized controlled trials—one from the United States, the other from Sweden—were published last year in the *Archives of Ophthalmology*, and their findings were a cause for celebration for ophthalmologists and subspecialists in glaucoma.[1,2] Intraocular pressure has traditionally been lowered pharmacologically or surgically in an attempt to prevent the disease from destroying sight long before randomized controlled trials were conceived. The rationale was based on indirect evidence. However persuasive this might have been, it did not protect against lingering doubts caused by observing patients progress relentlessly towards blindness despite apparently successful control of intraocular pressure or the fact that a substantial proportion of people with glaucoma have pressure that is always within the normal range. Some even proposed that raised pressure was effect, not cause—a failure of autoregulation because of interruption of biofeedback.

These doubts hindered advocates of population screening because evidence of effectiveness of treatment, a fundamental requirement, was not there. Eddy, in examining the economics of population screening in the United States, was one of the first to draw our attention to these deficiencies.[3] For a while we were locked into an ethical dilemma. Evidence was lacking that lowering pressure was effective, yet it was considered unethical to withhold treatment from a control group. The ethical imperative to produce the evidence gained ground after Rossetti's systematic review of the effectiveness of the medical treatment of chronic open angle glaucoma.[4] Out of 114 randomized controlled trials in the review, only eight attempted to assess effectiveness with a vision related outcome against placebo or control. Only three studies provided data on visual field and were included in a meta-analysis. This did not show a beneficial effect of lowering pressure on visual function.

Several comparative studies indicated an effect. The Moorfields laser medicine surgery trial indicated that best control was achieved by surgery, both for pressure and visual function, as did Jay's Glasgow trial.[5,6] Later, a more complex trial comparing different strategies for treatment of advanced

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