Virtual Mentor
American Medical Association Journal of Ethics
June 2001, Volume 3, Number 6: 179-182.

FROM THE EDITOR
Deconstructing Disparity
Audiey Kao, MD, PhD

"What brought you in today?" asked Dr. K.

"I have had attacks of lower abdominal pain for 1 year. The pain is located in the middle to right side of my lower abdomen," said Mrs. S, a 30 year-old, obese white woman who presents for her first office visit with Dr. K.

"Why have you come to see me today?" asked Dr. K.

"I have had attacks of lower abdominal pain for 1 year. The pain is located in the middle to right side of my lower abdomen," said Mrs. S, a 30 year-old, non-obese white woman who presents for her first office visit with Dr. K.

The only significant difference in these hypothetical clinical encounters is that one patient is obese and the other is not. The effect of obesity on clinicians' approach to patients with abdominal pain was recently assessed in a novel study by Wigton et al[1]. The investigators were concerned that widely held beliefs that obese people are "lacking in self-control, lazy, and poorly motivated" might be found among health professionals[2, 3] and that this stereotype would adversely affect their diagnosis and management decisions. Seventy-two 3rd- and 4th-year medical students were presented with video histories of simulated patients who presented with irritable bowel symptoms, but who differed in their body weight (normal versus obese). Based on this information, the medical students were asked how they would assess and manage these cases. Results of this study revealed no significant difference in diagnostic decisions and recommended management based on a patient' s weight, except for those that were medically indicated, such as blood glucose and dietary counseling. However, the study revealed that medical students were less confident that obese patients would be able to comply with the nutritional and exercise recommendations, and they were less likely to want obese patients in their medical practice.

Despite its methodological limitations (such as convenience sampling and the hypothetical nature of the clinical encounter), this study sheds light on the complex and challenging issue of physician biases and its impact on medical decision making. But more substantively, the study reflects a much larger and ongoing inquiry into not only the medical, but social, economic, and political factors that contribute to the persistent disparities in health among individuals and communities

in the US[4, 5, 6, 7, 8]. In light of national and global disparity in health, this month' s issue of the Virtual Mentor is dedicated to exploring and examining the variety of factors that lead to disparities in health among Americans and how physicians as professionals and as citizens can address this health crisis.

From an overall perspective, factors that maintain disparities in health and wellbeing fall into 2 broad categories: (1) health-related factors that can be modified by the health care system, and (2) factors such as poverty and illiteracy that require non-medical solutions to the social determinants of health disparities. A prime example of the latter, poverty, often results in a vicious cycle of health disparity that not only affects individuals but serves to concretize poor health across generations. Over this past decade, the percentage of individuals and families living below the federal poverty line has decreased significantly, and this is an encouraging sign. Yet, over this same period, the percentage of those without health insurance reached epidemic proportions with more than 16 percent of the US population still unable to afford health insurance, and millions more who have inadequate coverage. Efforts including the State Children's Health Insurance Program (SCHIP) and expanding coverage via tax credits are viable incremental solutions[9, 10, 11].

Ultimately, addressing the causes and consequences of social conditions such as poverty will demand participation and leadership from physicians in their roles as citizens of a civil society. We can give of our expertise to those in need, donate to charitable organizations, support those who advocate for effectual social policy, donate blood, register in a bone marrow bank, and always vote. Of course, this level of citizenry takes time, money, and effort, but as members of a society who are among its most affluent and well off, we must strive to live up to these obligations.

In addition to our responsibilities as citizens, we need to recognize how we may be contributing as physicians to inequities in medical care, and thus disparities in health. As noted in the above study by Wigton et al., evidence suggests that physician biases and patient stereotyping based on characteristics such as gender, race, appearance, and lifestyle may influence clinical decision making[12, 13, 14, 15, 16]. Reflecting on my professional training as a resident during a time when a significant segment of the hospitalized population comprised AIDS patients, I can find instances of professional bias. Most of the patients I saw had contracted AIDS through intravenous drug use or unprotected sexual intercourse, and I can still vividly recall that, in my first month as an intern, one psychotic patient was intent on infecting the hospital staff with the HIV virus. Suffice it to say, I was ill prepared for this situation, and would be less than honest if I did not admit to moments of frustration and anger at these AIDS patients. Fortunately for the patient's care, an intern does what he or she is told, whether it's securing central venous access or drawing blood for cultures. Fortunately for my professional development, I had mentors who advised and reminded me that as physicians, it is our responsibility to care for, not judge, our patients. Now that I am an older physician, I realize that it is naïve to think that physicians are completely immune

to the prevailing stereotyping and biases that exist in today's society. Thus it is critical that, as professionals, we realize our flaws and failings as we strive to meet our professional ideals as healers and physicians.

I hope that by providing an opportunity for us to reflect on this complex issue, this special theme issue of the Virtual Mentor will help our readers better appreciate and understand the myriad factors that contribute to disparities in health. I call on my colleagues to apply our expertise and leadership not only as professionals but also as citizens of a civil society in addressing our nation's health disparities.

References

1. Wigton RS, McGaghie WC. The effect of obesity on medical students' approach to patients with abdominal pain. *J Gen Intern Med*. 2001;16(4):262-265.
2. Price JH, Desmond SM, Krol RA, Snyder FF, O'Connell JK. Family practice physicians' beliefs, attitudes, and practices regarding obesity. *Am J Prev Med*. 1987;3(6):339-345.
3. Blumberg P, Mellis LP. Medical students' attitudes toward the obese and the morbidly obese. *Int J Eat Disord*. 1985;4(2):169-175.
4. Basu J. Access to primary care: the role of race and income. *J Health Soc Policy*. 2001;13(4):57-73.
5. Epstein AM, Ayanian JZ. Racial disparities in medical care. *N Engl J Med*. 2001;344(19):1471-1473.
6. Fiscella K, Franks P, Gold MR, Clancy CM. Inequality in quality: addressing socioeconomic, racial, and ethnic disparities in health care. *JAMA*. 2000;283(19):2579-2584.
7. Ayanian JZ, Cleary PD, Weissmann JS, Epstein AM. The effect of patients' preferences on racial differences in access to renal transplantation. *N Engl J Med*. 1999;341(22):1661-1669.
8. Ayanian JZ. Race, class, and the quality of medical care. *JAMA*. 1994;271(15):1207-1208.
9. Pauly M, Herring B. Expanding coverage via tax credits: trade-offs and outcomes. *Health Aff (Millwood)*. 2001;20(1):9-26.
10. Feder J, Levitt L, O'Brien E, Rowland D. Covering the low-income uninsured: the case for expanding public programs. *Health Aff (Millwood)*. 2001;20(1):27-39.
11. Kahn CN, Pollack RF. Building a consensus for expanding health coverage. *Health Aff (Millwood)*. 2001;20(1):40-48.
12. Chen J, Rathore SS, Radford MJ, Wang Y, Krumholz HM. Racial differences in the use of cardiac catheterization after acute myocardial infraction. *N Engl J Med*. 2001;344(19):1443-1449.
13. Giles WH, Ands RF, Casper ML, Escobedo LG, Taylor HA. Race and sex differences in rates of invasive cardiac procedures in US hospitals: data from the National Hospital Discharge Survey. *Arch Intern Med*. 1995;155(3):318-324.

14. Cantos JG, Allison JJ, Kiefe CI, et al. Relation of race and sex to the use of reperfusion therapy in Medicare beneficiaries with acute myocardial infarction. *N Engl J Med*. 2000;342(15):1094-1100.
15. Hooper EM, Comstock LM, Goodwin JM, Goodwin JS. Patient characteristics that influence physician behavior. *Med Care*. 1982;20(6):630-638.
16. Eisenberg JM. Sociologic influences on decision making by clinicians. *Ann Intern Med*. 1979;90(6):957-964.

Audiey Kao, MD, PhD is editor in chief of *Virtual Mentor*.