

## *Virtual Mentor*

American Medical Association Journal of Ethics  
June 2001, Volume 3, Number 6: 209-211.

### **PERSONAL NARRATIVE**

#### **Through the Physician's Eyes: The Despair of Health Disparities**

William McDade, MD, PhD

The disparity between health outcomes of minority groups and the majority white population in the United States has attracted a great deal of interest lately. Over 600 papers have been published in the last 10 years attempting to measure inequity in outcomes in dozens of diseases and conditions. There is now a Center at the National Institutes of Health dedicated to the study of health disparities. Today, it is very clear that your race or ethnicity can be an important variable in determining your predisposition to certain medical conditions. The problem that remains is how to use these data to adjust practices so as to eliminate the disparities. There are multiple impediments to accomplishing this, and, as physicians, we should commit ourselves to removing barriers that allow health disparities to exist.

The simplest barrier to overcome—absence of data on race and ethnicity—seems like a reasonable place to start, but that course is mired in racism, fear, history, greed, and inertia. Without data on race and ethnicity, no valid measures of disparity in outcomes can be made. Collecting data regarding race of patients seems easy enough to do; and those unfamiliar with the issue may assume that this information is already available. However, it is rarely available for study and review. Thus, whatever changes in practice studies may advocate, we cannot measure the extent to which the solutions implemented are efficacious without identifying the race of the patients. There are distracting arguments about what constitutes race and differences between groups. There is also distracting argument over who makes the classification, the patient by self-identification or the physician. Fear of discrimination prevents some individuals from giving this information, and fear of being sued for discrimination prevents some physicians, hospitals, and health systems from collecting it. In few instances is there a legal barrier to the collection of these data, yet many are under the impression that there are laws against it. Irrespective of the method used to classify patients, a system of consistent data collection must be implemented immediately. We need a stratification system based on race that everyone agrees to use and that is not subject to political whim or current fad. This system need not impose anything more on the individual than a way of counting that leads to consistent analysis of interventions used to correct health disparity.

An interesting question arises when an individual in the majority group fails to respond to questions regarding race in the health care setting. The fear of discrimination felt by minority people, predicated on historical social discrimination

in other arenas, does not apply here, so why would majority patients refuse to cooperate? There could be a self-serving reason. If one considers health care a zero-sum game, and disparities in health care are to be corrected to advantage minority patients, then this would imply to some self-interested majority patients that cooperation in collecting race data would disadvantage them. Greed concerning scarce resources should not be justification for not cooperating with the collection of race data. Likewise, fear of discrimination should not be a reason for withholding this information. In the latter case, safeguards should be implemented to prevent possible misuse of data. In the former case, assurances should be made that the elimination of disparities will not come at the expense of increasing the exposure of medical risk to the majority.

The human genome project has given us the insight that there may be greater biological similarities between humans of anthropologically different racial groups than between two given individuals within the same group. The Office of Management and Budget's Directive #15 states that race and ethnic categories have been socially and politically determined and were never intended to be used scientifically or biologically. The anthropology of race and disease has been used to "prove" the superiority of whites and should be abandoned as racist and morally corrupt. However, health patterns may be identified within groups that can point to solutions to reduce disease disparity. Explanations for disease disparity that are couched in arguments of biological determinism based on race and ethnicity should be abandoned. Rather, rational, strategic approaches should be devised that seek to eliminate the effect of poverty and culture on disease; that work to improve access to health care for all so that early identification of disease is enhanced; that are designed to improve social and environmental discrimination that leads to ill-health among minority groups; and that eliminate health illiteracy.

We as physicians, have a special role in reducing disparities. Physicians must acknowledge the role segregation plays in enabling cultural ignorance to be perpetuated in this country. We are all inadequately trained in understanding cultural nuances of those different from ourselves and how these elements impact our delivery of health care to patients. Morally responsible individuals do not like to think of themselves as racist, yet all must look within to determine whether the documented unequal outcomes experienced by minority patients is the result of unconscious thoughts or cultural arrogance. The concept of cultural competence has helped define standards in the training of medical students and physicians. Fear of additional standards, imposed mandates to provide services without compensation, and difficulties in measuring competence for certification purposes are barriers which prevent wide acceptance of the concept. However distasteful changing our practice or admitting cultural ignorance may be, health disparity results in preventable excess mortality, and thus we must bear the responsibility for our arrogance. A recently described replacement for cultural competence is the admission of cultural humility. It is the first step in recognizing our own weaknesses and thus provides the impetus to incorporate culture into our clinical

decision making and to recognize the ultimate impact of cultural competence on the health care of our patients.

William McDade, MD, PhD is chairman of the Governing Council of The American Medical Association Minority Affairs Consortium. He is an assistant professor at The University of Chicago in the Department of Anesthesiology and Critical Care and is principal investigator in a laboratory conducting research in sickle cell disease. He is chairman of the Admissions Committee of the Pritzker School of Medicine and is president of the Cook County Physicians Association, the Chicago chapter of the National Medical Association.

*The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.*

Copyright 2001 American Medical Association. All rights reserved.