Health Care Disparities Called 'Medical Error'

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — Health care disparities among ethnic groups should be considered a form of medical error, James Gavin, M.D., said at a consensus conference on patient safety and medical system errors in diabetes and endocrinology.

"When we see disparities, that really is a reflection of inadequate patient safety," said Dr. Gavin, who is past president and professor of medicine at Morehouse School of Medicine, Atlanta. "It means that under the same or similar conditions of risk or exposure, the outcomes are sufficiently different that there is some disadvantage conferred on one of the other subject populations."

One example is coronary heart disease (CHD), he said at the conference, sponsored by the American Association of Clinical Endocrinologists. "There is a real difference in CHD mortality in black males, compared with whites at every age stratum; it doesn't start to even out until you get to the ninth decade of life. I'd be very concerned about these kinds of numbers."

Results like these are in part a reflection of how medical decisions are made for different patients, and, sometimes, the only way to get at that information is by looking at surrogates for decision making, such as utilization rates, Dr. Gavin said.

For instance, coronary artery bypass graft surgery (CABG) has proved to be of significant benefit in high-risk patients, and yet "CABG is significantly underutilized in blacks, compared with whites," he said. On the other hand, data on amputation among patients with diabetes "suggest it is significantly more utilized in blacks, compared with whites. Something is driving these outcomes."

Researchers are finding that even when minorities have equal access to health care, an inequity still exists in the services they receive.

Part of the problem may be bad information, he suggested. A report from a commission chartered in the 1980s by Health and Human Services Secretary Margaret Heckler found several myths about heart disease in black patients, including the idea that black patients rarely had myocardial infarctions or angina, or that they were immune to CHD.

"Because of flaws in the way data were interpreted, they were actually underreporting CHD as a cause of death, when … CHD was actually the leading cause of death in U.S. blacks then just as it is now," Dr. Gavin noted.

Now that researchers are looking at disparities more systematically, they are finding that even when minorities have access to health care that is equivalent to that of white patients, there is still an inequity in the services they receive, he said.

"That part of the gap that is attributable to patient needs and patient preferences you have to back out [of the equation] because you can't blame a patient's choice," he said. "But these other issues, the way the system operates, the way individual and group biases and prejudices [affect things], those issues are major drivers."

Medicare data on diabetes care show that something is clearly "amiss," he continued. "For example, despite the greater prevalence and risk associated with it, African Americans are less likely to undergo hemoglobin A_{1c} testing, or to have their lipids tested, or to have vaccinations. And this is in the Medicare population, where coverage is not the issue."

In another instance of disparities in diabetes care, "African Americans are 12% of the population, but fully a third or more of the [end-stage renal disease] population," he said. "They also are less likely to receive a kidney transplant and less likely to be referred for a transplant, or to be placed on a transplant waiting list. Those are decisions that someone has to make."

Some of the disparities arise from the clinical encounter itself. "It's at that level we have to begin to pay more attention because it is only to the extent that we improve the quality of this encounter . . .that we will begin to influence this process," Dr. Gavin said. "There will be less ambiguity, less misunderstanding, and we'll begin to mitigate the influence of prejudices, no matter who brings them to the table."

Dr. Gavin said he didn't agree with the idea of "cultural competency." "It's not something I'm convinced we ever become competent at. It's always a work in progress. But [we] can work to become more self-aware of our own cultural norms and values that will quickly lead us to misjudge or miscommunicate with others."

One problem with cultural competency training, for instance, is that it can confer a false level of confidence, he noted. "We think we can go to one workshop and come out culturally competent, when in fact it's lifelong learning. And we have to be careful not to reinforce cultural stereotypes."

Finally, even those who do attend such courses should remember that they do not substitute for having culturally representative health care teams. "We can never lose sight of that," he said. ■

Minority Recruiting Efforts Are Paying Off at Massachusetts General

BY SHERRY BOSCHERT
San Francisco Bureau

SAN DIEGO — Expanding the staff and scope of its Multicultural Affairs Office over the last 4 years helped increase the numbers of African American, Native American, and Hispanic medical residents who opted to train at Boston's Massachusetts General Hospital, said Elena B. Olson, the office's administrative director.

Founded in 1992 to increase diversity specifically in the department of medicine, the office expanded to eight employees (many of them part time) in 2000 to collaborate with all 20 residency programs at the hospital in recruiting, retaining, and advancing underrepresented minorities at the hospital.

"It appears that we are one of the few hospitals that actually do this," Ms. Olson said. Massachusetts General competes with other hospitals in the Harvard University system for residency applicants.

Ms. Olson and Dr. Ronald Dixon, the office's manager of trainee affairs, hope that the hospital's model can be used by other institutions to increase the number of physicians from underrepresented minority groups.

They presented the first public description of the program at the annual meeting of the National Medical Association.

Data on residency matches collected by the office since 2001 show that the annual percentage of underrepresented minorities who match with residency programs at the hospital has improved to 10%, which parallels the proportion of underrepresented minorities in medical schools. In 2002, the office helped match residents to programs at the hospital that traditionally had failed to attract underrepresented minorities—such as all the surgical services, she said.

The "ranking match rates"—the number of medical students ranked high on the hospital's match list that chose to come to Massachusetts General—improved in the last few years as well.

In 2001, the hospital ranked 62 underrepresented minority applicants for acceptance, and the rankings of 21 of these students matched them with residency programs there.

In 2002, 33 of 62 underrepresented minorities matched with the hospital. In 2003, 21 of 51 matched. And in 2004, 26 of 62 underrepresented minorities matched with the hospital's training programs. "Our recruitment efforts were paying off," she said.

The rank-to-match ratio was higher for underrepresented minorities, compared with residency applicants overall. In 2003, 41% of underrepresented minorities and 34% of applicants overall matched with the hospital. In 2004, 42% of underrepresented minorities and 36% of applicants overall matched with the hospital.

The office offers the hospital's 20 residency program directors two levels of assistance. First, an introductory letter invites applicants to consider training there and gives them contact information for staff and current minority residents. Beyond that, the office can arrange informal meetings, provide funds for applicants to visit the hospital, and make some follow-up contacts.

The office also coordinates an 8-week summer research trainee program for minority college students to encourage them to pursue careers in medicine. Strengthening the pipeline of students "is crucial to building a robust resident pool," she said. ■

Disparities Among Women Vary by Ethnic Group

WASHINGTON — More programs need to be developed to address the specific health needs of minority women, Elena Cohen said at the annual meeting of the American Public Health Association.

"Racial minorities are projected to make up almost half the population by 2050," said Ms. Cohen, senior counsel at the nonprofit National Women's Law Center. "But there's not much analysis of [health data on] racial and ethnic groups by gender."

To further examine the issue, the center analyzed data on women's health from all 50 states and the District of Columbia. The center's report, "Making the Grade on Women's Health," outlines disparities in women's health care in different states.

For example, black women have the highest rate of Pap smears and the lowest rate of osteoporosis, compared with other groups, but they also have the shortest life expectancy and the highest poverty rate, and they are least likely to get prenatal care. They have the highest mortality rates for coronary heart disease, stroke, and diabetes, and the highest incidence of AIDS and lung cancer, Ms. Cohen noted.

Latinas have the lowest mortality rate from stroke but are the second-least likely group to be screened for cervical cancer, and they fare worse than other groups in cervical cancer incidence and mortality, she said. This group has the highest percentage of uninsured women and the highest percentage of women who do no physical activity in their leisure time.

American Indian and Alaskan Native women had the second-lowest morality rate from stroke, but they fared worst of all groups for smoking, binge drinking, mortality from cirrhosis, and violence against them, Ms. Cohen said.

"The Asian-American/Pacific Islander group fared best in preventive health behaviors and in avoiding obesity and smoking, but these women do have other issues," she said. But the report noted that cervical and ovarian cancer disproportionately affect these women, who are the second least likely group to have had a mammogram within the last 2 years.

—Joyce Frieden