Health Care Gap Affects Patient Safety, Outcomes

Even when access is equal, there is an inequity in services provided between minority groups, others.

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."

Part of the problem may be bad information, he said. A report from a commission chartered in the 1980s by Health and Human Services Secretary Margaret Heckler found several myths about heart disease in blacks, including the idea that blacks 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 account for 12% of the population, "but fully a third or more of the [end-stage renal disease] population," Dr. Gavin explained. African American patients 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 health care 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 attend such courses should remember that attendance does not substitute for having culturally representative health care teams. "We can never lose sight of that," he said. ■

A Solution to Health Disparities: Improved Health IT

BY JOYCE FRIEDEN
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WASHINGTON — Improving health information technology could go a long way toward eliminating disparities in health care, Newt Gingrich said at a meeting sponsored by the Alliance of Minority Medical Associations, the National Association for Equal Opportunity in Higher Education, and the Department of Health and Human Services.

"The challenge is not to be futurist but to bring health care up to the world of the last 20 years," said Mr. Gingrich, former speaker of the House of Representatives and founder of the Center for Health Transformation.

He criticized a recently adopted Florida law that requires physicians to print legibly when they write prescriptions. "First, it's a fantasy to think legislation will convince doctors to print legibly. Secondly, it's the wrong direction for change," he said. "Even a clearly printed prescription remains a paper prescription and misses all the opportunities for checking medication errors, checking other medications, and seeing if there are contraindications. In the long run, the future is an electronic prescription with an expert system to make sure you get the right medication."

People will need to think more creatively, he continued. "Imagine that the medical profession went to major cell phone manufacturers and said, 'We want you to develop a camera capability on a cell phone sufficiently vivid that we could do emergency diagnostics by phone.' "

At the same time, the health care industry needs to find better ways to standardize itself and to disperse information about best practices in medicine, Mr. Gingrich continued. "It can take 17 years for a best practice to reach the average doctor," he said. "We want to set a standard and migrate everybody to that standard."

He gave an example of how electronic health records could improve the standard of care. "A friend's father went in for an MRI, and her mother went in with him. They filled out five paper forms before the MRI. The mother happened to go into the doctor's office as they were preparing to do the MRI, and she said, 'You did know he has a pacemaker?' They stopped right there."

But if the patient had had an electronic health record, "that would have been obvious and automatic, and the expert system would check against it," Mr. Gingrich said, noting that his center is trying to develop "a 21st-century intelligent health system which we believe will end health disparities in America in terms of the delivery of services."

However, such a system would not improve disparities based on culture or ethnicity unless certain problems are addressed, he continued. For example, "diabetes is largely a cultural issue. How you treat diabetes is a medical issue, but how you avoid diabetes is a cultural issue."

Since obesity plays a part in the development of diabetes, he urged audience members to push their home states to institute mandatory, 1-hour daily physical education in public schools and also to ban unhealthy foods from the schools. States that don't do these things "are not serious about obesity in children," he said.

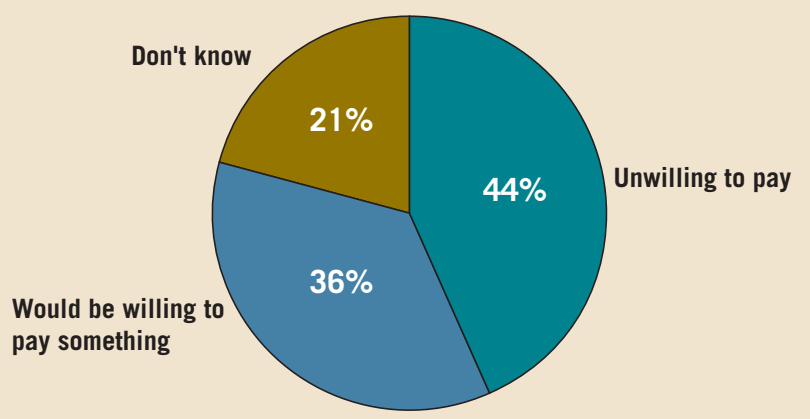
After electronic health records are in place in hospitals and physicians' offices, the next step should be a "Personal Health Knowledge System," Mr. Gingrich continued. The system would be accessible to patients online and would contain genetic profiles that might tell patients such things as whether they have a particular genetic makeup that puts them in the 10% of people who should not eat too many high-fiber foods because doing so could trigger colon cancer, he said.

"You should actually know your DNA before you go grocery shopping," he said. "Within a decade, we'll have an expert system where you'll be able to punch in your health status and it will print out a grocery list."

In fact, food purchases also can be used as an incentive: "If you want to truly help health disparities among the poor, you may want to give bonus points if you use food stamps for the right foods," Mr. Gingrich said. "That sounds like micromanagement, but we've got to be practical about how to shift behavior patterns when people are used to eating food that kills them." ■

DATA WATCH

Nearly Half of Patients Unwilling to Pay for Online Communication With Their Physician



Note: Based on a nationwide survey of 2,387 adults conducted Feb. 4-8, 2005. Percentages do not add to 100% because of rounding.
Sources: Harris Interactive, Wall Street Journal Online

Kevin Foley, Research/Louise Koenig, Design