From Unequal Treatment to Quality Care

Risa Lavizzo-Mourey, MD, MBA, and John R. Lumpkin, MD

We congratulate the American College of Physicians (ACP) on its position on racial and ethnic disparities (1). The position is comprehensive and consistent with the ACP’s mission and can be a model for other specialties and disciplines. The emphasis on enhancing cultural competency is worthy of note because of the role such competency can play in improving outcomes. As noted in the position statement, competency among all health care professionals and support personnel is critical to achieving better outcomes. Not only must practicing physicians be diligent in acquiring cultural competency skills through continuing education, they must ensure that those supporting them in their practices do the same.

Translation services are essential to providing culturally competent care because they are key to communication when the clinician and the patient do not speak the same language. Evidence shows that professional translation services are associated with improved patient satisfaction and adherence, as well as improved provider satisfaction (2). For these reasons, clinicians should use professional translators and should consider them to be essential participants in clinical encounters with patients who do not speak the same language. We should not rely on volunteers, who are often family members, friends, or untrained support staff, because this is not consistent with best practices for culturally competent care. Unfortunately, payers do not reimburse for interpretive services, but this shortsightedness does not absolve clinicians of the professional responsibility to provide them. The ACP has taken a strong and commendable position on reimbursement of translation services, especially for Medicare, Medicaid, and the State Children’s Health Insurance Program (SCHIP). To make progress on its agenda for racial and ethnic disparities, the College must place this issue at the top of its policy agenda. Effective communication is a prerequisite for high-quality care.

Cultural competency training and interpretive services are good foundations for eliminating racial disparities in health care, but they are just a good beginning. We must also focus our efforts on addressing the subtle forms of bias, such as stereotyping. Many aspects of bias are based on an unconscious cognitive adaptive strategy—stereotyping—that enables people to make sense of a complex environment. But stereotyping can also negatively affect communication between the patient and physician. As noted in the Institute of Medicine report “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” (3), research on stereotyping and practical approaches to eliminating it is an essential part of the comprehensive, long-term set of solutions required to eradicate racial and ethnic disparities.

Closing the gap by eliminating the disparities in care between racial and ethnic groups and white populations in the United States is not enough. Unfortunately, even when we close the gap, we will not achieve an acceptable level of care for many conditions. For example, Cooper and Hickson (4) demonstrated disparities between minority and white children enrolled in Medicaid in getting corticosteroid therapy after an emergency department visit. Sadly, the rates of follow-up therapy for all groups fell far short of the ideal. The ACP’s leadership and strong commitment to closing the gap and raising the bar are commendable. If the ACP can translate its excellent position statement into a sustained program to change practice, it can make a difference for all patients in this country.


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The Patient’s Role in Reducing Disparities

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When the world’s largest medical specialty society articulates 8 laudable and compelling position statements for reducing disparities in health care in the United States (1), the call for action must not get lost in niggling debates over the details of implementation. Yet the details are precisely where the difficulties lie. In dealing with these difficulties, the leadership of U.S. medicine must question whether some of the proposed solutions will actually produce better health care for minorities.

Although some patients may prefer to see a physician of the same race, ethnicity, or sex, empirical evidence that this form of concordance alone improves the quality of interpersonal or technical care is, at best, mixed (2–7). In a carefully designed, multimethod study, for example, Cooper and colleagues (2) found that although patients were more satisfied when seen by physicians of the same race, actual audiotapes of their visits showed no increase in patient-centered communication compared with the audiotapes of visits in which the patient’s race differed from the clinician’s race. Earlier research suggests that minority patients seeing nonminority physicians may actually be more actively involved in treatment decisions than when the physician’s race is the same as the patient’s race (7). Greater diversity in the physician workforce is essential. However, the evidence suggests that relying on racial concordance to resolve communication problems between physicians and patients is unlikely to improve quality of care substantially.

Training physicians in cultural competence is also unlikely to solve the problem of racial disparities. While “cultural competence” or cultural sensitivity should be an integral part of early physician training, practically, physicians cannot be taught the interior of every culture they could encounter in practice. How should we ensure that physicians are trained in the appropriate cultures once they are outside of the training environment? The cultural context of a physician’s practice is a moving target. Physicians relocate. And the cultural face of major urban centers changes as the “dominant” minority cultures change with successive waves of immigration.

A more appropriate focus for physician training is the specific skill sets that will help physicians to identify the discrete features of a patient’s culture that may impede effective implementation of treatment or interfere with optimal health outcomes. Physicians can be taught certain elements of physician–patient communication—such as using effective participatory decision-making styles, looking patients in the eye, and interrupting patients as infrequently as possible—that produce better outcomes of care in patients of all socioeconomic backgrounds (7–10). Training physicians to focus on these elements of interpersonal communication is a more achievable goal than the far more daunting challenge of achieving “universal” cultural awareness and competence.

Focusing solely on physicians and the clinical setting is meeting only half the challenge. Even the most culturally competent, racially or ethnically concordant physician who sees a patient with chronic disease every 2 to 3 months for 15 to 20 minutes cannot be expected to address the individual patient’s complex and unique barriers to effective care. Preparing all patients to make the most of those brief office visits must be a major focus of future efforts to reduce disparities. Many tested patient training programs increase patient participation in treatment decisions. These programs are as effective in improving the outcomes of care among poor and minority populations (9–12) as they are in the general population. Minority patients could also be encouraged to bring advocates or family members to the office or hospital to be translators or “negotiators” for lifestyle-appropriate treatment decisions. Promising preliminary research suggests that using these patient advocates, “navigators,” or community-based “coaches” may be effective in improving the quality of chronic disease care for minorities (13).

Calling for patients to be trained as meaningful, not just token, comanagers of their health care is far from a new notion. But its widespread implementation in ethnic and minority populations, while an enormous political, social, and economic challenge, may reduce disparities in the practice and effectiveness of U.S. medicine.

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Diversifying the Racial and Ethnic Composition of the Physician Workforce

Neil R. Powe, MD, MPH, MBA, and Lisa A. Cooper, MD, MPH

This position paper from the American College of Physicians states that a diverse workforce of health professionals is an important part of eliminating disparities among racial and ethnic groups in the United States. An implicit assumption underlying this position is that increasing the number of ethnic minority providers will not only reduce health care disparities but also improve the health of minorities. Arguably, the most definitive and direct evidence for this assumption would be a clinical trial that randomly assigned patients to minority and majority physicians and followed them longitudinally while assessing changes in objective measures of health status. This trial does not exist and is extremely unlikely to be performed because many patients would object to random assignment to physicians. Choosing a physician is a very personal matter that most people who have a choice do not leave to chance.

Since direct evidence does not exist, one could try to construct a chain of logic by using observational data from separate studies. This chain might lead inexorably to the conclusion that a diverse workforce would improve health. However, is this chain of logic? Ample evidence suggests that minority physicians are more likely to return to communities from which they came and that minority physicians are more likely to treat patients with lower socioeconomic status (2–7). While evidence has shown that more health care (and possibly physician care) does not always lead to better health status in relatively well-insured populations (8, 9), providing health care to a geographic area where none to little existed may influence health status.

Furthermore, concordance (patients and their physicians sharing similar characteristics, such as race or ethnicity, language, and sex) is associated with better patient-reported outcomes. In race-concordant visits, patients are more satisfied with their care and feel that they are more involved in decision making about their care (10, 11). Language concordance also has these effects and results in improvements in self-reported health status (12, 13). Unfortunately, we do not clearly understand why concordance leads to better patient-reported outcomes. If we did, we could teach all physicians how to achieve these outcomes rather than random assignment to physicians. Choosing a physician is a very personal matter that most people who have a choice do not leave to chance.

In arguing to expand the number of minority clinicians, is it necessary to claim that concordance improves health outcomes? Suppose that patients’ health status was the same in race-concordant and race-discordant relationships. Would not patients choose to enter a relationship that brought greater satisfaction and participation in decision making? Some patients might even prefer greater satisfaction and participation in health care to slightly better health status, although this is unproven.

Furthermore, projections from the 2000 U.S. Census indicate that the U.S. population will grow more diverse from 2000 to 2050 (18% to 27.9% ethnic minorities and 12.6% to 24.4% Hispanics) (14). Many believe that the social and economic future of the United States depend on how well the workforce reflects the population it serves. They argue that diversity can bring value not only through better services but also through better workforce functioning. Other segments of our global society recognize this
value. So might the health care industry. Therefore, although the direct evidence that increasing the diversity of the physician workforce improves health status is not ironclad, we believe that the College’s position paper takes a reasonable stance in supporting actions to diversify the health professional workforce.

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Will Racial and Ethnic Disparities in Health Be Resolved Primarily Outside of Standard Medical Care?

Theodore Pincus, MD

I agree with almost every point in the position paper (1), including the 6 fronts addressed: increased access to quality health care, patient care, provider issues, systems that deliver health care, societal concerns, and continued research. The first 2 fronts, however, present a “physician-centric” perspective, which implies that the major advances to eliminate racial and ethnic health disparities will emerge from one-on-one encounters in the examination room. This view reflects a “biomedical model” paradigm (2), in which physicians, rather than patients or the society, are responsible for good health. This model is spectacularly successful in high-intensity, acute medical care, the setting of most medical education and training, but has many limitations when applied to general health and chronic diseases.

Perhaps the most convincing evidence of limitations of the biomedical paradigm is seen in the strong associations of socioeconomic status and health (3). Job classification predicted cardiovascular mortality more effectively than cholesterol level, hypertension, or smoking in London civil servants, all of whom had access to the National Health Service (4). In the United States, people who do not complete high school have a substantially higher prevalence of cardiovascular, gastrointestinal, pulmonary, renal, and musculoskeletal disease (but not most types of cancer, allergies, thyroid disease, or multiple sclerosis) compared with high school graduates (5). Sociodemographic factors explain in large part, although not entirely, the higher mortality rates in black people compared with white people (6). The health status of educated minorities is far closer to that of the educated white population than to that of poor minorities. Conversely, poor white populations and poor minorities have similar but lower health status. These relationships are largely independent of access to medical services (6).
One important limitation of the biomedical model is an underlying assumption that patients with access to needed resources will implement any recommended evaluation and therapy on the basis of medical necessity. However, experienced physicians recognize that most patients often do not implement what might be best for their health. Lower rates in black patients than in white patients of adherence to recommendations for angioplasty and coronary bypass surgery (7), joint replacement surgery (8), and willingness to donate blood or cadaveric kidneys (9) are explained at least as much by belief systems, mistrust, and religion as by limited access to these interventions. These and many other observations suggest that patient self-management and social conditions appear to be as important as actions of health professionals in determining long-term health (3). Furthermore, according to strong evidence, medical insurance minimally contributes to eradicating socioeconomic differences in health (10). Indeed, health disparities have widened over the past 3 to 5 decades despite the National Health Service in the United Kingdom, Medicaid in the United States, and other measures (3, 11, 12), as acknowledged in the position paper (1), which cited a report by the Centers for Disease Control and Prevention (13).

The latter 4 fronts in the position paper present more promise. Provider issues are important. Surely, all physicians could improve their capacities to communicate with patients about beliefs that lead to poor choices about health behaviors and health care. Systems that deliver comprehensive health care by providing transportation to the site of care, patient education, and other services might improve the health outcomes that we currently achieve. Societal concerns that transcend the examination room may be crucial—for example, expenditures on new school textbooks may advance health more than a new magnetic resonance imaging scanner.

We need to think beyond a biomedical model toward a biopsychosocial model (2). Research should help us to understand the true causes of disparities in the health of patients of minority or low socioeconomic status so that we can move beyond our well-intentioned but often oversimplified thinking that improved access and higher-quality medical care are the primary arenas for important progress. As greater insights are gained into underlying causes of disparities, our definition of quality will incorporate more ideas from a biopsychosocial model (2, 3), which recognizes the importance of social conditions and community effects on health outcomes.

Rudolf Virchow, the founder of modern cellular pathology as a cornerstone of the biomedical model, said more than 150 years ago that “the improvement of medicine would eventually prolong human life, but improvement of social conditions could achieve this result now more rapidly and more successfully” (14). He also said that “the physicians are the natural attorneys of the poor, and the social problems should largely be solved by them.”

These prescient ideas suggest that returning to our roots as “healers,” in the largest sense of the word, may lead to real progress toward reducing disparities in health due to minority or low socioeconomic status. I hope that the pages of this journal will become a forum for new ideas and approaches and that we will look back on this ACP position paper as opening a new chapter in medical care.

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