

Do Doctors Discriminate by Race?

By Sally Satel and Jonathan Klick

Two 50-year-old men arrive at an emergency room with acute chest pain. One is white and the other black. Will they receive the same quality of treatment and have the same chance of recovery? Many experts today insist that bias in the doctor's office will lead to poorer treatment of the minority patient. This notion has taken hold in medical schools, health organizations (the American Public Health Association issued a call for "Research and Intervention on Racism as a Fundamental Cause of Ethnic Disparities in Health"), and in Congress, where Democrats proposed a health bill "to end discrimination...and expand the Office of Civil Rights."

To be sure, minorities as a group have poorer health status. Compared to whites, infant mortality rates are higher, life expectancy is lower, and the prevalence of diabetes, asthma, and obesity, for example, are higher. But there is little compelling evidence supporting the idea that racially biased doctors are a cause of poor minority health.

The notion of physician bias was popularized in 2002 by a report from the Institute of Medicine (IOM) called "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." It found that, on average, white patients get certain procedures (e.g., catheterization) more often than black patients, and concluded that "bias," "prejudice," and "discrimination" with-



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in the doctor/patient relationship was a major, though not exclusive, cause.

But the conclusions were not supported by data. In fact, the IOM authors put far too much weight on studies in which important data were missing. The most rigorous studies reviewed by the IOM sought to control for confounding clinical or economic variables, such as concurrent illness, supplemental insurance, or patients' refusal to undergo procedures. But because most of the studies were retrospective and relied upon chart

review or large Medicare administrative databases, many such variables could not be captured.

Details that figure importantly in physician decision making—like EKG subtleties, position of occlusion in carotid and coronary vessels, coronary ejection fraction, and pulmonary function test performance—will not show up in most after-the-fact reviews.

Moreover—and this is critical—these unrecorded variables do vary

by race and ethnicity.

Racial bias need not be at work. More compelling explanations for the treatment gap exist. Two factors in particular have far more potent influence on the quality of care an individual receives, irrespective of race: the doctor pool available to the patient, and where the patient lives.

Peter Bach of Memorial Sloan Kettering Cancer Center and his colleagues showed that white and black patients, on average, do not visit the same population of physicians. Moreover, the doctors frequented by black patients were often not in a position to provide optimal care. Bach's study, which appeared in the *New England Journal of Medicine* in 2004, found that physicians who treated a large number of black patients were more likely to answer "not always" when asked whether they had access to high-quality specialists (such as cardiologists or gastroenterologists) or services like diagnostic imaging or home health assistance.

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Along the same lines, a 2002 study by researchers at the Harvard School of Public Health found that physicians working for Medicare-managed care plans in which black patients were heavily enrolled provided lower quality care to *all* patients, regardless of race. Specifically, their patients were less likely to receive the four clinical services the authors measured: mammography, eye exams for diabetics, beta-blockers after a heart attack, and follow-up after hospitalization for mental illness.

Similarly, a team at the Center for Studying Health System Change in Washington, D.C. assessed the abilities of a random sample of physicians to obtain medically necessary services for their patients. According to the survey, black physicians were more likely to report difficulties admitting patients to hospitals than were white physicians, and Hispanic physicians were more likely to report having a poor specialty-referral network than white physicians.

Where you live matters a lot

The second important factor is that access to quality care, irrespective of the race of the patient, is tied to geography. With racial and ethnic groups tending to cluster in particular localities, it is imperative that researchers account for geography in evaluations of health disparities. When they do, they discover that geographic residence often explains race-related differences in treatment better than even income or education.

Consider the effects of location on health disparities in infant mortality rates. Jeannette Rogowski and colleagues at the RAND Corporation used a rich data set to examine the effects of hospital quality on the mortality rates of very low birthweight babies. They controlled for race, as well as gestational age, method of delivery, birth defects, prenatal care, and the condition of the baby at birth.

The authors found that black and white babies tended to be delivered at different kinds of hospitals. Black babies were significantly more likely to be born in government-run institutions serving a relatively high proportion of Medicaid patients, and where doctors spent less time with patients, mostly due to high patient volume. Furthermore, the hospitals where many black babies were born were significantly less likely to have neonatal intensive care units or to perform neonatal cardiac surgery.

Other examples of regional inconsistencies in treatment further undermine the biased doctor notion. For example, one region might display wide race disparities in some procedures, such as hip replacement or back surgery, smaller discrepancies in bypass, and almost no gap in mammograms. Does that mean that doctors in the region who perform hip replacements are biased, but cardiac-care doctors are not? Or is it possible that there are other, benign reasons for those statistical disparities?

Improving care for all

If physicians cannot fairly be accused of bias, does this shift the charge of bias to the healthcare system? In other words, do black patients receive poorer care because they are black? Or is it because they have, on average, lower incomes and social capital (for example, less capacity for negotiating complex systems), and are disproportionately mired in neighborhoods with weaker medical systems?

The most recent report from the Agency for Healthcare Research and Quality separately examines treatment quality by race and by income. It says that “remote rural populations” receive comparatively poorer care, as do “many racial and ethnic minorities and persons of lower socioeconomic positions.” In short, white people who live in these areas get bad care too. Conversely, black people living in wealthier areas tend to get good care. In other words, class makes a much greater contribution to health status and the quality of care

than race does.

Much has been made of the need for greater sensitivity in the doctor-patient relationship. Common sense dictates that patients benefit when they trust their physicians and interact with them productively. But the remedies for unsatisfactory doctor-patient relationships do not reside in racial sensitivity training for health care professionals, affirmative action in medical school admissions, or the specter of civil-rights litigation against doctors—all avenues of redress that have been proposed of late.

Since class makes a much greater contribution to health care and health status than does race, sound solutions should target all underserved populations. Low-income patients could benefit from grassroots outreach through black churches, social clubs, and worksites; patient “navigators” to help negotiate the system; language services; and efforts to get more good doctors into distressed neighborhoods. Seemingly simple innovations, such as clinic night hours, mobile clinics, and more extensive use of school nurses, could be a great boon to patients who risk a loss of income, or even their jobs, by taking time off from work for doctor’s appointments.

In a recent monograph, we reviewed a range of research and concluded that differences in treatment do indeed vary *by* race, but not *because* of it. Reform efforts should therefore focus on the influence of so-called “third factors” correlated with race—such as wealth, insurance status, and geographic location. Words such as “prejudice” and “discrimination” are divisive, and health campaigns premised on alleged bias by physicians will only distract health care professionals from coming up with the practical solutions we need to help underserved patients of all races.

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