We all strive to provide quality health care to our patients and families. But what exactly is quality health care? The Institute of Medicine defines it as care that is timely, efficient, effective, safe, patient-centered and equitable. Here Dr. Stephen Nelson, director of the Hemoglobinopathy Program and co-director of the Vascular Anomalies Center at Children’s Hospitals and Clinics of Minnesota, examines equity in health care, specifically for black Americans. He spoke on the DMU campus Sept. 3.

While many factors affect health care equity, disparities based on race that target communities of color are consistently reported in the management of many diseases. For example, blacks receive a lower standard of care than whites when being treated for breast cancer, orthopedic problems, cardiovascular disease, pain and end-of-life care, among other conditions. According to the 2014 National Healthcare Disparities Report, many of these discrepancies are not decreasing. Being uninsured was the single strongest predictor of quality of care. However, when correcting for insurance and socio-economic status, blacks still receive worse care than whites.

These discrepancies raise the question: In what ways does racism shape disparities in care and, specifically, perpetuate health care disparities for people of color?

**BACKGROUND**
For 22 years I have had the honor of caring for the majority of children with sickle cell disease (SCD) in Minnesota. About 100,000 Americans are living with SCD. Although SCD is a global disorder, the vast majority of Americans with the disease are black. I have only recently begun to consider how, as a white male physician, my race may affect the health care delivery to our patients of color. This consideration is long overdue.

Barriers to racial health care equity include the health care system (insurance, funding, white domination in provision of care), the patient (poor health literacy, fear, mistrust), the community (awareness, advocacy) and we the providers (bias, attitudes, expectations).

The fact that Americans with SCD are black might not be a concern if there were not significant gaps in private and public funding for clinical care and research between diseases affecting blacks and whites in our country. In 2004, the National Institutes of Health (NIH) spent $90 million on SCD and $128 million on cystic fibrosis (CF), a disease that predominantly affects whites—despite the fact that there are three times as many Americans with SCD. When philanthropic support from the CF Foundation and the Sickle Cell Disease Association of America is considered, the per-capita support for patients with CF is $5,074, compared to $6 per person with SCD. These gaps are even more disconcerting when we consider that SCD is the most commonly detected disease in newborn screening programs across the United States.

**PATIENT PERSPECTIVE**
From early medical experimentation on slaves, starting in the 17th century, to the Tuskegee experiments from 1932 to 1972, to coerced sterilization of young black women (which was legal until 1974 in areas of the South), to present-day attitudes about AIDS contraction, the history of racism in medicine (and health care overall) toward black Americans has undoubtedly shaped this community’s lack of trust in the health care system. This legacy of racism and the resultant mistrust may partially explain racial disparities, as it may decrease black patients’ willingness to follow evidence-based recommendations made by (predominantly white) physicians.

**PROVIDER PERSPECTIVE**
Medical staffs’ perceptions and awareness levels also affect the health care that patients receive. Several studies have shown that race and sex influence physicians’ management decisions. With respect to provider bias, SCD patients are perceived as being opioid-dependent at twice the rate of other patients with pain. In one study, both staff and families in a sickle cell center perceived whites getting better service than blacks. In a larger study of health care delivery, providers of color and women providers perceived race as an issue, whereas white male providers tended to not see race as a factor in health care delivery. In a recent study, white providers prescribed hydroxyurea (the only FDA-approved drug to treat SCD) less frequently than did black providers.

**IDENTIFYING PERCEPTIONS OF RACE AND RACISM**
Lack of provider awareness of institutional racism and the resultant structural barriers that patients of color face are areas that need examination. Given that typically there is no intentional or direct training...
regarding racism in nursing or medical schools, and given that there has been no direct training at my own institution about these issues to mitigate the presence of societal racism, it is not surprising that providers have very little understanding of the complexities of racism and its manifestations in provision of health care or in society as a whole.

Richard Salas, Ph.D., director of multicultural affairs at DMU, is doing amazing work at the University. The Diversity Health Series (DHS) he has brought to the campus is on a course to change this in profound ways.

NEXT STEPS

Health care provider attitudes must change in order to reduce health care disparities associated with race. Diversity and cultural competency trainings are already in place at many institutions. While they have been shown to be successful in fostering an appreciation and awareness of difference, as well as developing the tools necessary for cross-cultural communication, they have not addressed the core of racism and, therefore, fall short of being able to truly effect change in racial disparity in patient care.

Dr. Heather Hackman and I have developed a training module for staff at our institution to help providers address individual racial bias, the role of racism in evidence-based medical protocols, and the realities of systemic racism and its impact on patients. The ultimate goal is to improve provider attitudes and provider confidence in caring for patients and families of color. I had the honor of presenting the results of our work to kick off the DHS at DMU in September.

The training module will:
• address the definition of race/racism and history of the social construction of race
• differentiate among diversity, cultural competency and social justice
• explore our current health care system (racial make-up of providers, how insurance became tied to employment, what we’re taught/not taught in school, evidence-based medicine, racial disparities)
• examine racism/whiteness in our society, including examples of racism/whiteness in medicine
• examine how race affects each of the Institute of Medicine’s six measures of quality care, and provide trainees tools for understanding these effects
• introduce critical thinking tools for improving medical providers’ comfort and skills in caring for patients of color.

Although our study focused on white providers and black patients, the findings and future directions can be applied across all aspects of health care delivery. Dismantling racism and provider bias will remove at least one of the barriers to racial equity in health care. We physicians have the greatest ability to affect change in this area. Until racial issues are honestly addressed by members of the health care team, it is unlikely that we will see significant improvements in racial health care disparities for Americans.

Stephen Nelson, M.D., joined the hematology/oncology program at Children’s of Minnesota in 1993. For the past five years, he has been studying, researching and training in the recognition of the impact of provider bias on racial disparities in health care. With Heather Hackman, Ph.D., a consultant on issues of racism and white privilege, gender oppression, heterosexism and homophobia, and classism, he conducts trainings for health care providers, public health officials and others in Minnesota’s Twin Cities.