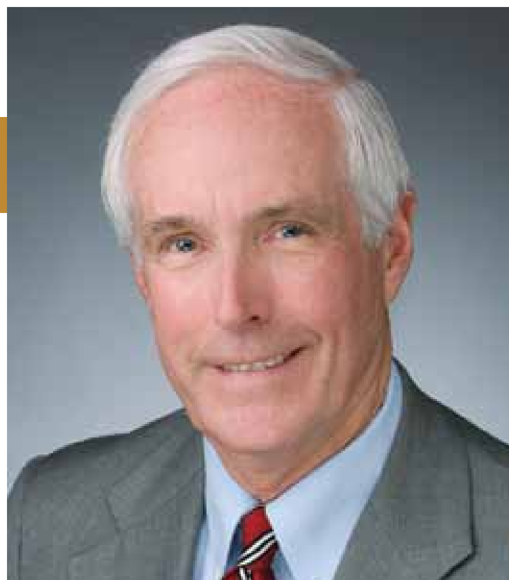
From my perspective



> "The need to address disparities in care—especially ethnic and racial divides—is growing increasingly urgent."

The Chair of the American College of Surgeons' Board of Regents, L.D. Britt, MD, MPH, FACS, classifies the geographic, economic, and ethnic disparities in the U.S. health care delivery system as the civil rights issue of this era. I agree wholeheartedly. Too often patients receive lower-quality care, have greater difficulty accessing medical services, or have to pay more for treatment simply because of demographics. These variances have no place in a humane and just society and are ethically and morally antithetical to the medical and surgical professions, which are grounded in the principle that all patients deserve to be treated with compassion and respect, regardless of race, location, or income.

Persistent problems

Whereas the U.S. has made some significant strides in eliminating disparities in access to mammograms, smoking cessation counseling, and appropriately timed antibiotics, many of the most significant disparities persist. For example, African-Americans are more likely than are Caucasians to be admitted to the hospital for lower extremity amputations due to diabetes and are less likely to receive appropriate prenatal care during the first trimester of pregnancy. Native Americans also are less likely to receive prenatal care, and they are less likely to undergo colon-rectal cancer screening. Meanwhile, Asian-Americans are less likely than whites to receive timely care for an illness or injury, and Hispanics are three times more likely to contract AIDS.[*]

Under our current system, access to health care is largely determined by whether an individual has health insurance, and minority populations are far more likely to lack coverage. Among nonelderly adults, at least 36 percent of Hispanics and 33 percent of Native Americans are uninsured. In addition, 22 percent of African-American, 17 percent of Asian, and 13 percent of white adults are uninsured. Adults in all racial/ethnic groups who lack insurance coverage are at least twice as unlikely to visit a physician as insured patients. Furthermore, Hispanics and African-Americans have differential access to a primary care physician or specific source of care, with Hispanics at particular risk.[†]

Regardless of race or ethnicity, low-income people receive less patient-centered, continuous care. For example, the percentage of patients who have their blood under control is significantly lower for poor than for high-income people, and low-income individuals are much less likely to receive recommended care for colon cancer. Low-income Americans also are two to three times as likely as high-income individuals to report problems receiving timely treatment. Furthermore, poor Americans are less likely to have a specific source of ongoing care.[*]

Geographic variances also are notable. For example, there was nearly a 20 percent gap in the proportion of nonelderly Minnesotans and Texans who were uninsured in 2004–2005. There also is wide variability across state lines in the odds of a patient undergoing certain common Medicare procedures, such as carotid endarterectomy, cholecystectomy, colectomy, aortic aneurysm repair, and back surgery.

In addition, rural patients have less access to appropriate care than their counterparts in met-

*Agency for Health Care Quality and Research. *National Healthcare Disparities Report, 2008*. Available at http://www.ahrq.gov/qual/nhdr08/nhdr08.pdf. Accessed May 13, 2009.

†The Henry J. Kaiser Family Foundation. *Eliminating Racial/Ethnic Disparities in Health Care: What Are the Options?* Available at http://www.kff.org/minorityhealth/h08_7830.cfm. Accessed May 13, 2009.

ropolitan areas. Indeed, more than 25 percent of Americans live in communities with fewer than 50,000 residents, but only nine to 12 percent of surgeons practice in nonmetropolitan areas.‡

Possible solutions

The need to address disparities in care—especially ethnic and racial divides—is growing increasingly urgent. If these variances in care continue unchecked, many more Americans will be at needless risk of requiring costly emergency and acute or end-of-life care, thereby threatening our nation's economic and moral fabric. So, what can the surgical profession do to help close these divides?

Some experts claim that one mechanism that may be useful is the development of patient-centered medical homes, where services are aligned to care for the whole patient. Indeed, evidence already exists to show that racial and ethnic differences in getting needed medical care are eliminated when patients are part of a medical home.

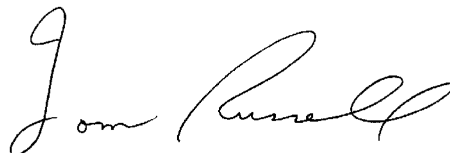
To address the challenges facing rural populations, we should foster training programs that provide surgeons of the future with the skills they need to treat the full range of conditions they are likely to encounter in this environment. We also need to develop a more regionalized health care system and encourage the federal government to provide incentives to surgeons who opt to practice outside of urban areas.

We need to attract more people of all races and creeds to medicine. Diversity within the physician population leads to improved access to services, increased patient satisfaction, and the delivery of culturally competent care. Minority physicians are more likely to treat minority and medically indigent patients and to practice in underserved communities. When given the option, minority patients are more likely to choose a health care professional of their own racial/ethnic heritage, and relationships between patients and physicians with similar backgrounds are characterized by higher levels of trust and mutual respect.

To encourage more minority students to enter the health care professions, medical schools need to provide opportunities for positive interaction among individuals from a range of backgrounds. A multicultural environment forces people to challenge their assumptions about individuals from different backgrounds and broadens their worldview.

Most importantly, however, we need to change our professional culture. We need to place greater emphasis on the tenets of our noble calling: to provide the best possible, ethical, and compassionate care to all who people who entrust us with their health care. We need to produce physicians and other health care professionals who are more culturally aware and better able to communicate with the broad section of people needing our services.

The ACS logo indicates that this organization calls upon its members to "serve all with skill and fidelity." We must remain true to this ideal and work to overcome disparities in care.



Thomas R. Russell, MD, FACS

‡Division of Advocacy and Health Policy. A growing crisis in patient access to emergency surgical care. *Bull Am Coll Surg*. 2006;91(8):8-19.

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.