

REMOVING BIAS FROM HEALTH CARE

Studies Show that Women and African Americans Often Get Inferior Care

The events of September 11, 2001, and its aftermath have affected U.S. society in a multitude of ways. One unfortunate reaction is our suspiciousness of people of foreign origin, especially those of Islamic descent. A more fortunate reaction is our new awareness that the United States is a multicultural society—not so much a “melting pot” as an “alphabet soup” culture. A recent editorial in *US Airways Attache* noted that between 1990 and 1998 the population of metropolitan Washington, DC, grew by 250,000 legal immigrants, from 193 different countries.¹ What are the implications for us?

What, especially, are the implications for health care? Before September 11, we Americans generally felt that we provided the best possible health care service to any person who sought it. Was that the case? More important, is it the case now? Have we really kept a blind eye to people’s backgrounds, ethnic origins, and nationalities?

INEQUALITY OF HEALTH CARE

The recent report issued by the Institute of Medicine (IOM), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*,² gives irrefutable evidence of inequality in the delivery of health care. Those of us—physicians, nurses, technicians, administrative personnel—who work for Catholic organizations must especially ask ourselves whether cultural, racial, or ethnic bias affects the way we deliver care. We are called not only to conform to civil law and codes of professional ethics but also to the *Ethical and Religious Directives for Catholic Health Care Services* and to the articulated values of our particular Catholic organizations.

We have traditionally believed that those who come through our doors are given care without regard to background, ethnicity, race, religion, or

national origin. Unfortunately, the data concerning access to care do not necessarily bear this out. The IOM report should occasion serious discussion, debate, and, finally, substantive action on the important—but too often unnoticed—effect that unequal access and treatment have on our society.

In a recent article, I noted that inequality of access has in fact existed in U.S. health care institutions for some time.³ In 1999, for example, racist remarks made by radiologists at an Atlanta hospital were inadvertently captured on tape and given to a medical transcriber. Learning of these remarks, John Ed Fowler, MD, president of the Medical Association of Georgia, said, “The patient-doctor relationship is the chief principle in our code of ethics, and the action of these physicians is simply unacceptable. . . . Physicians who break this trust with their patients should not be practicing. . . . Whether unequal medical treatment is caused by differences in income and education or social and cultural factors, [it is] unjustifiable and will not be tolerated [by the association].⁴

One hopes that the race of patients will not cloud the judgment of the physicians who treat them, thereby resulting in unfair treatment. All practitioners have a responsibility to exercise the best medical judgment and make the best treatment decisions, regardless of patients’ race, gender, age, or other extraneous factors. After all, practitioners have taken an oath to provide care to all who seek their attention.⁵

Not-for-profit institutions are governed by their charter as a public trust to ensure that everyone who enters their doors should be treated with dignity and respect, even if that means transcending institutional policies and practices that have failed to take demographic changes into account. It is true that health care institutions are

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merely microcosms of the greater society. Because our society is a multicultural one, the people who operate health care facilities may have different values than those who seek treatment in them; such differences may affect the treatment given. Most of us who work in Catholic facilities know we must respond to a higher standard, ensuring that all staff adhere to expected values and

ethical responsibilities and treat patients equally. This is not true everywhere, however. A 1993 study published in *JAMA* suggested that race, rather than financial capability, was the primary factor affecting the type of treatment offered to minority patients in Veterans Affairs health care facilities.

These studies [the authors concluded] have shown that white patients are more likely than black patients to undergo various invasive cardiac procedures, such as cardiac catheterization, percutaneous transluminal coronary angioplasty (PTCA), and coronary artery bypass grafting (CABG). These differences persist despite adjustment for potential confounding variables such as age, sex, clinical factors, socioeconomic status, and insurance status.⁶

A study described in the *New England Journal of Medicine* endeavored to determine if race and sex were factors in the use of reperfusion therapy for patients who had had myocardial infarctions. According to the authors:

In this national sample of 25,575 Medicare beneficiaries . . . white women were as likely as white men to receive reperfusion therapy . . . However, blacks, regardless of sex, are significantly less likely than whites to receive this potentially lifesaving therapy. . . . [A] likely explanation for our findings is that the decisions of physicians, as a result of clinical ambiguity, lack of adequate training, insufficient knowledge, or physicians' own preferences or biases, contributed to the racial differences we observed in this study.⁷

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issues related to diversity without mentioning disparities in the care of women. Many people assume that the word "diversity" concerns only race or ethnicity. Nothing could be further from the truth. The available literature makes it quite clear that the care received by men differs from that received by women, including women of European descent as well as those of other ethnic back-

grounds. An article in the *New England Journal of Medicine* described differences found among men and women who had had hip or knee replacement surgery because of severe arthritis. The authors concluded that

although women were more likely than men to seek treatment for arthritis and had similar levels of self-reported coexisting conditions, women with a potential need for arthroplasty were less likely than men to report having ever discussed arthroplasty with a physician. These findings are provocative and suggest that a possible explanation for the observed sex differences in the potential need for arthroplasty may be that women are less likely to be referred, or perhaps are referred after a longer interval, to orthopedic surgeons for consideration for arthroplasty.⁸

There may be a number of reasons for this apparent inequity, ranging from insufficient communication between the patient and the caregiver, on one hand, to physicians' views concerning the suitability of candidates for particular surgeries, on the other. Nevertheless, a good deal of data suggests that women tend to be discriminated against when it comes to the arthroplasty procedures described in the article.

Despite the strides that women have made over the past decade and a half, moving into positions of influence and increasing their numbers as health care providers in both community and academic settings, statistics show that they continue to get inferior care for a range of problems, including heart disease, diabetes, osteoporosis, Alzheimer's disease, breast cancer, and domestic violence. Disturbing also are the differences seen among women patients themselves. As a former

U.S. surgeon general has noted, "If we look at death rates for diseases of the heart, African-American women are clearly at risk, with a staggering 147 deaths per 100,000, compared to 88 for white women, 70 for American Indian/Alaska Native women and 63 each for Hispanic women and Asian-American/Pacific Islanders."⁹

We know that mortality and morbidity data are affected by genetic and cultural influences. But the perspectives, competence, and behavior of practitioners are significant factors as well. It is imperative that we who work in health care be neither shy nor defensive about our quest for the truth regarding the behavioral, genetic, environmental, and occupational factors that influence our current health care delivery system.

Reflecting on this issue is unsettling, especially for those who, like us, serve faith-based organizations. Knowledge of such disparities is so disturbing that it may rock our sense of fairness as it concerns quality in treatment and clinical outcomes. We all like to think that when we present ourselves to a provider, we will encounter no bias regarding race, gender, nationality, or other medically irrelevant factors in the consideration of treatment options. The inequalities discussed here are not always a reflection of prejudice or preconceptions on the part of institutions or practitioners. Lifestyle, heredity, education, compliance, and other related socioeconomic factors also affect outcomes. Even so, the evidence suggests that different kinds of people receive different medical services and that some groups have less access to advanced medical technology than other groups. Some authorities would argue that racial bias is the only primary reason for the health disparities seen in the epidemiological and biostatistical data. One must agree that there is enough evidence to conclude that both behavioral and environmental factors contribute to different outcomes. These differences should be addressed vigorously.

BON SECOURS' STATEMENT

The reality is that health care providers are human. Human dynamics—background, experience, learned and unlearned behavior—affect every aspect of our lives, manifesting themselves in countless

Bias affects both the provision of care and its outcomes.

ways in our actions and interactions with each other. These dynamics are certainly involved in such issues as diversity, hiring, promotion, and others. Therefore, we who serve Catholic health care can expect thoughts and sentiments that are inconsistent with our ministry's mission, vision, and values to occasionally creep into our actions. Precisely because this is so, we must focus on this important issue.

The *Ethical and Religious Directives* importantly articulate several dimensions of this matter. Indeed, our awareness of this issue needs to be heightened. At a minimum, we should begin a dialogue on how to deal with the impact of bias as it affects both the provision of care to certain populations and the clinical outcomes of that care. As Directive 3 puts it:

In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor, the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.¹⁰

The "Shared Statement of Identity for the Catholic Health Ministry," developed by members of the Catholic Health Association (CHA), emphasizes the importance of this topic for participating organizations.¹¹ One CHA member, Bon Secours Health System, Inc., (BSHSI), Marriottsville, MD, stresses Catholic identity in its Values and Operating Principles statement, which includes a pledge to "promote and defend human dignity." Because (the pledge continues) "each person is created in the image of God (Gn 1:27), each one is sacred and possesses inalienable worth, and is social by nature and finds fulfillment in and through community. Catholic

healthcare, therefore, treats individuals—and their families and various communities—with profound respect and utmost regard.”¹²

BSHSI further promises to “promote each person’s dignity (worth) and we defend their dignity and their right to reach their potential. This belief is the basis for the BSHSI Values of *respect* and *growth* and its Operating Principle of superior *understanding of those we serve*.”

In a continuing series of bullet points, the BSHSI statement also promises to provide:

- **Care for Poor and Vulnerable Persons:**

Because Jesus had a special affection for poor and vulnerable persons (Mt 25:34-40), Catholic healthcare distinguishes itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination. Catholic healthcare is characterized by its efforts to alleviate the conditions that perpetuate the structures of poverty and vulnerability in society. . . . It is essential that BSHSI always consider and serve the needs of those who are poor, dying, vulnerable and on the margins of society. The BSHSI Value of *justice* deals with this imperative and the *commitment to unmet needs* is the corresponding Operating Principle.

- **Act on Behalf of Justice:** Because justice is an essential component of the Gospel of Jesus (Mt 5:1-12), Catholic healthcare strives to create and sustain right relationships both within the ministry and with those served by the ministry. Toward this end, Catholic healthcare attends to basic human needs for all (including accessible and affordable healthcare) and seeks structures that enable the full participation of all in society, the equitable distribution of societal resources, and the contribution of all to the common good. . . . BSHSI strives to create and sustain right relationships within the organization and with those whom we serve. We promote, defend and advocate for the rights of all people and for the common good. The BSHSI Value of *justice* supports this belief and action.

As we who serve Catholic health care reflect on our stewardship and review our organizational initiatives, we must be mindful of our community needs and especially aware of the quality of our services. We must look closely at the needs of all who come through our doors and view them in light of quality indicators as part of our overall

quality program. At BSHSI, in accordance with our Ethics, Care of the Dying and Diversity Quality Plans, we are developing accountable systems that acknowledge our progress toward high-quality care. We intend these plans to be responsive to the local unique universe of our patients’ particular issues.

DATA ANALYSIS

How do we in Catholic health care address the challenges involved in serving diverse populations? As we continue to expend considerable resources on information technology to evaluate clinical quality for the Joint Commission on Accreditation of Healthcare Organizations and other entities, it will become increasingly necessary for us to “slice” our data in ways that reflect the race, ethnic and social backgrounds, and genders of our patients. Some will question the need for more data. But if we are to live up to our values, we will need such data to keep from being lulled into a false sense of security about what we are doing in our institutions. Alignment with our stated values can be measured, at least in part, by quantitative clinical data.

But information and decision support systems must mature to become more integrated. It is no longer enough to have strong financial, human resource, and clinical care systems that are not capable of disaggregating the data into descriptive patient-specific slices. A strong clinical care information system would allow us to better address key ethical and public policy challenges. To leverage clinical data in this public discussion, we must integrate these systems into public health databases, report them on “community report cards,” and make them an integral part of our strategic planning processes. Although capturing such data may be initially difficult, we will, by doing it, enhance our ability to report and analyze outcomes. As the authors of an article on the subject noted several years ago:

Demand for evidence-based accountability is an outcomes-management reporting system [, including] internal continuous quality improvement in real time, external reporting and accountability to multiple groups, and tracking patients over time to assess trends and examine the long-run impact of improvement interventions. . . . External reporting requirements will be driven by such organizations as the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations. This will require aggregating data across patients and physicians to derive intermediate and

outcome measures of both service and clinical quality such as immunization rates, mammography screening, and selected risk-adjusted morbidity and mortality rates.

. . . Clinical information will become the lubricant for outcomes reporting, and outcomes reporting in turn will be at the heart of accountability between physicians and multiple stakeholders.¹³

We must look our respective communities in the eye and say, "When you come to our doors, you will be assured that opportunities for services are not reflective of race, gender, or economic biases." The outcomes may not be the same for all patients—because, as we've noted, heredity, educational background, and lifestyle choices, among other factors, do have an impact on health status. But we can assure all patient populations that everyone will be afforded the same advanced technology. For Catholic health care systems, public assurance is a matter both of advancing the common good and of respecting the dignity of all who come to us for care.

OUR PARTNERS

Opportunities for launching such a public dialogue will be accompanied by a great deal of emotion and heated debate from numerous organizations (e.g., community-based groups, physicians, trade groups). We are all aware of the fact that most of the care at the institutional level is driven by individual private practitioners. We must encourage those individual members of our medical staffs to use their skills in a manner that is nonbiased. To say the least, this will be a sensitive topic with which to approach staff physicians; but we must approach them. After all, members of a medical staff are people who, like the rest of us, inevitably reflect the mores of the larger society, bringing their backgrounds, experiences, philosophies, and biases to their medical practice. Evidence of this can be seen in the Associated Press's report of the incident at the Atlanta hospital mentioned earlier:

Three [radiologists] were barred from working at a hospital and fired from a radiology practice for making racist remarks that were caught on a hospital tape recorder that they thought was shut off. [A fourth radiologist named in the lawsuit was cleared.] The comments were recorded by a medical transcriber . . . who sued the doctors, Atlanta Medical Center, a radiology contractor, and a transcription company. [The medical transcriber], who is black, alleged she was fired after she complained. . . .

One doctor used a racial epithet to refer to blacks, and the others made disparaging comments.¹⁴

Of course, human motivation is shaped by many factors: economic, cultural, geographic, religious, and others. I do not want to suggest that white physicians alone are the problem, for they are not the only ones guilty of insensitive or discriminatory behavior.

Social considerations—including wealth and status in the community—influence the way some practitioners relate to their patients, as do the practitioner's orientation, training, and geographical origins. I have frequently heard nonwhite people describe the caregivers they encountered in hospitals and emergency rooms as "indifferent," "uncaring," "unresponsive," and "uncommunicative." The caregiver just "doesn't hear me," they often say. Of course, the vast majority of physicians, nurses, and technicians do not behave this way. But too many do.

Because they have not always been treated respectfully, some populations tend to avoid hospitals and physicians and, as a result, sometimes develop misconceptions about health and health care. One writer, aware of this tendency, urges clinicians to

determine whether patients' fundamental assumptions about the risks and benefits of medical interventions are accurate. Misinformation should be corrected. This process should be incorporated into the education of medical students, resident physicians, and the continuing education of practitioners. These strategies ultimately should help patients make authentic choices that are truly guided by informed decisions and not limited by truncated opportunities or historical circumstance.¹⁵

One can only hope that we health care providers act on the issues and challenges outlined in *Unequal Treatment* as we have acted on those discussed in the IOM's previous reports, *Crossing the Quality Chasm* and *To Err Is Human*.

THE CATHOLIC HEALTH CARE MISSION

Although all health care organizations should address possible disparities in access and treatment, the issue is especially pressing for Catholic organizations. As my colleague Ed Gerardo, chief development officer, Bon Secours St. Francis Medical Center, Midlothian, VA, has put it:

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BECOMING A PHYSICIAN EXECUTIVE

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and contacts in an industry that is constantly and rapidly changing. Networking is an area of development that is often ignored or postponed by the busy physician leader whose mind-set often remains that of a lone ranger. Indeed, the importance of having a support network may not become clear until the new physician executive confronts a major workplace dilemma or—worse—is fired. The aspiring physician executive will find that keeping a file of the names, addresses, phone numbers, and personal data of trusted colleagues—and periodically reaching out to them—will probably be more valuable over the long term than socializing at meetings and conferences.

AN AWESOME CHALLENGE

It is not enough for physician executives to be competent clinicians. They must also possess and demonstrate outstanding communication and managerial skills. They must effectively blend administrative and medical acumen into a seamless package—an awesome challenge that requires adaptability, good judgment, and a talent for taking action in the face of uncertainty, unfamiliarity, and the negative thinking of some colleagues. But effective physician executives lead *beyond* the bottom line; they create environments that encourage teamwork, innovation, and necessary change. □

NOTES

1. Niccolo Machiavelli, *The Prince*, P. F. Collier and Son, New York City, 1909.
2. Witt Kieffer, *CEOs in 2000*, Charles Thomas, Springfield, IL, 2001, pp. 45-49.
3. R. Hardwood, "A Profile of Hospital Executives," *Modern Healthcare*, vol. 47, no. 4, 2001, pp. 12-16.
4. American College of Physician Executives, *The Making of a Physician Leader*, Tampa, FL, 2000, pp. 36-43.
5. Stephen R. Covey, *The 7 Habits of Highly Effective People*, Simon & Schuster, New York City, 1989.

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For Catholic health care providers today, the challenge of discerning the proper course of action is all the more exacting because of the nature of the activity and the values inherent in a religious organization. . . . Good quality care is the essential and tangible reflection of a provider's intent to honor the dignity and promote the well-being of the person. Moreover, although all providers are expected to go beyond corporal concerns and attend to patients' emotional and spiritual needs, faith-based providers have an expressed accountability to patients and families to provide the necessary services that address these needs.¹⁶

Those who provide health care in a faith-based setting should take care to align care delivery with their organization's stated mission and values. For Catholic organizations, such alignment clearly requires a demonstrated commitment to the dignity of every person, to social justice, and to advancement of the common good.

Catholic organizations should engage in a formal process of self-reflection, reviewing their clinical and administrative practices in light of these values and mandating improvement where those values are not being honored in day-to-day practice. In cases where racial, cultural, or gender bias is found to interfere with care delivery or treatment, a truly values-based organization will take prompt and compassionate action to see that such interference comes to an end. □

NOTES

1. Stephen M. Wolf, "Our Changing Face," *US Airways Attache*, March 2002, p. 8.

2. Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Institute of Medicine, Washington, DC, 2002.
3. Everard O. Rutledge, "The Struggle for Equality in Healthcare Continues," *Journal of Healthcare Management*, September-October 2001.
4. Rutledge, pp. 314-315.
5. Rutledge, p. 315.
6. J. Whittle, et al., "Racial Differences in the Use of Invasive Cardiovascular Procedures in the Department of Veterans Affairs Medical System," *JAMA*, August 26, 1993, pp. 621-627.
7. John G. Canto, et al., "Relation of Race and Sex to the Use of Reperfusion Therapy in Medicare Beneficiaries with Acute Myocardial Infarction," *New England Journal of Medicine*, April 13, 2000, pp. 1,097-1,098.
8. Gillian A. Hawker, "Differences between Men and Women in the Rate of Use of Hip and Knee Arthroplasty," *New England Journal of Medicine*, April 6, 2000, p. 1,020.
9. David Satcher, "American Women and Health Disparities," *Journal of the American Medical Women's Association*, Fall 2001, p. 131.
10. U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Washington, DC, 2001, p. 9.
11. Catholic Health Association, "A Shared Statement of Identity for the Catholic Health Ministry," St. Louis, 2001; see www.chausa.org/IDENTITY/IDENTITY_PROMO.ASP for the statement and a description of its development.
12. "Catholic Identity Resource Tool, Version 1.0," Bon Secours Health System, Marriottsville, MD, September 2001.
13. Stephen M. Shortell, et al., "Physicians as Double Agents: Maintaining Trust in an Era of Multiple Accountabilities," *JAMA*, September 23, 1998, p. 1,107.
14. "Doctors Fired over Racist Remarks," Associated Press, Atlanta, October 8, 1999.
15. Jeffrey N. Katz, "Patient Preferences and Health Disparities," *JAMA*, September 26, 2001, p. 1,508.
16. Edward F. Gerardo, "Organizational Ethics Case Study: The Bon Secours Richmond Contract Renewal," *Health Progress*, September-October 2001, pp. 41-42.

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