TRENDS & *Ideas*

Sim Gellman

ACCESS TO HEALTHCARE

The Plight of Uninsured Latinos

Latinos are less likely than any other ethnic group in the United States to have health insurance coverage, R. Burciaga Valdez and colleagues report in *JAMA*.

The authors used the 1980 and 1990 Current Population Surveys to compare the insurance status of nonelderly Latinos with Anglo, black, Asian, and other populations. The data revealed that 39 percent of Latinos are uninsured, compared with 13.8 percent of Anglos and 24 percent of blacks. Mexican and Central and South American Latinos are nearly twice as likely to be uninsured as Puerto Ricans and Cubans. In the past decade, the number of uninsured Mexican Americans increased by 150 percent. Uninsured Central and South Americans increased by 328 percent.

Valdez and colleagues suggest that the rapid Latino population growth and the restructuring of the economy have been especially important in increasing the number of uninsured Mexicans and Central and South Americans in the United States. They note that Latinos and Mexican Americans have more dependents per worker than Anglos or blacks. In addition, many Latinos work in low-skill, poorly paid jobs, which are less likely to provide health insurance coverage. They are also more likely to work for small employers. Finally, a large percentage of Latinos live in states that severely restrict eligibility for Medicaid services.

The authors project that extending Medicaid coverage to all poor people would reduce the proportion of uninsured Latinos by 37 percent, whereas mandating that employers provide coverage would produce a 22 percent reduction. Combining these methods would lower the number of uninsured Latinos by 54 percent.

But even if such strategies were implemented, a significant percentage of Latinos would remain uninsured, the authors warn. They note that requiring employers to provide insurance may force some "to lay off workers, keep wages low, or go out of business." Moreover, expanding Medicaid eligibility "could create severe state budget crises."

Valdez and colleagues suggest that a "rededication to consumer-sponsored comprehensive prepaid health plans" might be the best alternative. As an example, they point to the Group Health Cooperative of Puget Sound, which offers area residents job training, educational opportunities, and primary healthcare. "Current debates about health care reform," they conclude, "must take into account the structural problems we face in providing medical care, especially in Latino communities."

MEDICINE

Americans' Use of Unconventional Therapies

Acupuncture and massage therapy may sound like quackery to some physicians, but many of their patients are using them anyway—without consulting or informing their doctor.

More than one-third of 1,539 respondents to a national telephone survey said they used at least one unconventional therapy for a serious or bothersome medical condition in 1990. The 3 most frequently used of the 16 unconventional therapies identified are relaxation techniques, chiropractic, and massage, note David M. Eisenberg and colleagues in the *New England Journal of Medicine*.

Of respondents who saw a provider of unconventional therapy in 1990, 89 percent "did so without the recommendation of their medical doctor." And 72 percent "did not inform their medical doctor of their use of the therapy." This finding "suggests a deficiency in current patient-doctor relations," note Eisenberg et al.

The authors speculate that physicians mistakenly assume patients do not use unconventional therapies for serious medical problems like cancer or diabetes. Eisenberg and colleagues also believe physicians "lack adequate knowledge of these techniques." They warn physicians that their patients may suffer as a result of this breakdown in communication, "since the use of unconventional therapy, especially if it is totally unsupervised, may be harmful."

When taking a medical history, physicians should ask patients about the use of unconventional therapies, advise Eisenberg et al. In addition, they recommend that medical schools teach about unconventional therapies and the clinical social sciences—anthropology and sociology.

NURSING

Advocating Patient Self-Determination

The 1990 Patient Self-Determination Act is creating new challenges for nurses in their role as liaison between the patient and the hospital care team, Charles Meyer reports in the *American Journal of Nursing.*

The law requires facilities that receive Medicare and Medicaid funding to inform patients of their right to be involved in treatment decisions. According to clinical nurse specialist Barbara Gill, many nurses see the law as an opportunity to extend their role as patient advocates.

After several years of discussing these issues with patients, Gill has found that one of the best ways to foster forethought about end-of-life treatment decisions is to encourage patients to talk about what makes life worth living for them. She also stresses the need to get family members together to discuss plans and options.

Careful documentation of patients' wishes is critical, according to Patricia Murphy, chairperson of the American Nurses Association's (ANA's) task force on the nurse's role in end-of-life decisions. Gill adds, however, that documentation is no substitute for ensuring "as early as possible that, if an advance directive exists, everybody on the team knows." Nurses should also read the advance directive themselves, rather than depend on another's interpretation of it.

Nurses should be prepared for potentially difficult situations, such as when a physician initiates aggressive treatment against the patient's wishes. In this circumstance, nurses should approach the physician with the assumption that he or she has the patient's best interests in mind, suggests Cindy Hylton Rushton, who is also on ANA's end-of-life task force. If this approach fails—and it seems clear that the physician's actions go against the patient's advance directives—the nurse can go to the hospital's ethics committee.

Multidisciplinary discussions of hypothetical situations can also avert potential conflicts, Gill suggests. She notes that talking over their approach to end-of-life treatment decisions can help care givers understand others' attitudes and principles and establish ground rules.

But even when care givers have—and abide by—a clear directive not to use "heroic measures" to prolong life, they may still have questions about the kind of care they should provide. Murphy points out that measures to reduce or eliminate pain can often be as aggressive as treatments intended to keep a patient alive. Nurses have found that the most critical steps in managing pain at the end of life are to continually assess the patient's condition and advise family members of the purpose and nature of these interventions.

HUNGER

A Growing Pain

The number of persons experiencing hunger in the United States is on the rise. But advocacy groups and federal agencies cannot agree on how many persons are hungry. Nor can they agree on what hunger is, its causes, or how to alleviate it, reports Felicity Barringer in the *New York Times.*

The Washington, DC–based Food Research and Action Center estimates that in any given month 4.7 million children experience hunger. The center on Hunger, Poverty and Nutrition Policy at Tufts University has reported that, at any given time, 30 million persons in the United States are hungry. But Benjamin Caballero, a physician at Johns Hopkins University's School of Public Health, says the figure is closer to 15 million.

Even experts disagree on the definition of the problem. "Conservatives avoid using the word hunger, saying that what the country is looking at is 'misnourishment'—bad food, as opposed to no food," notes Barringer. Some factions believe hunger in the United States results from a lack of resources; others blame it on a *waste* of scarce resources such as on the purchase of junk foods. "But," Barringer notes, "the disagreements are overshadowed by a growing consensus that the increase in poverty has been accompanied by an increase in undernourishment, particularly in children."

Even still, antihunger advocates cannot agree on how to crush the problem. "What needs to be done is helping make people more self-sufficient, extending Federal programs and making food stamps more accessible," says Laura Sherman, assistant to the director of the Center on Hunger, Poverty and Nutrition Policy. But food "doesn't solve the problem of the roots of poverty causing behavior disorders and feeding disorders in young children," counters Steven Parker, a pediatrician at the Failure to Thrive Clinic of Boston City Hospital. He adds, "If you want a child to develop normally, you have to feed him first, and supplement that with environmental stimulation and enrichment."