

rates of medical errors that made patients feel vulnerable and less trustful of the U.S. health care system. The increased media and academic attention to problems related to quality of care (and of disparities themselves) has clearly diminished trust in doctors and nurses.

Trust is a crucial element in the therapeutic alliance between patient and health care provider. It facilitates open communication and is directly correlated with adherence to the physician's recommendations and the patient's satisfaction. In other words, patients who mistrust their health care providers are less satisfied with the care they receive, and mistrust of the health care system greatly affects patients' use of services. Mistrust can also result in inconsistent care, "doctor-shopping," self-medication, and an increased demand by patients for referrals and diagnostic tests.

On the basis of historic factors such as discrimination, segregation, and medical experimentation, blacks may be especially mistrustful of providers. The exploitation of blacks by the U.S. Public Health Service during the Tuskegee syphilis study from 1932 to 1972 left a legacy of mistrust that persists even today among this population. Other populations, including Native Americans/Alaskan Natives, Hispanics/Latinos, and Asian Americans, also harbor significant mistrust of the health care system. A national Kaiser Family Foundation survey of 3884 individuals found that 36% of Hispanics and 35% of blacks (compared with 15% of whites) felt they had been treated unfairly in the health care system in the past because of their race/ethnicity. Perhaps even more alarming, 65% of blacks and 58% of Hispanics (compared with 22% of whites) were afraid of being treated unfairly in the future on that basis (Fig. 16e-8).

This mistrust may contribute to wariness in accepting or following recommendations, undergoing invasive procedures, or participating in clinical research, and these choices, in turn, may lead to misunderstanding and the perpetuation of stereotypes among health professionals.

KEY RECOMMENDATIONS TO ADDRESS RACIAL/ETHNIC DISPARITIES IN HEALTH CARE

The publication *Unequal Treatment* provides a series of recommendations to address racial and ethnic disparities in health care, focusing on a broad set of stakeholders. These recommendations include *health system interventions*, *provider interventions*, *patient interventions*, and *general recommendations*, which are described in more detail below.

Health System Interventions • COLLECTION AND REPORTING OF DATA ON HEALTH CARE ACCESS AND USE, BY PATIENTS' RACE/ETHNICITY *Unequal Treatment* found that the appropriate systems to track and monitor racial and ethnic disparities in health care are lacking and that less is known about the disparities affecting minority groups other than African

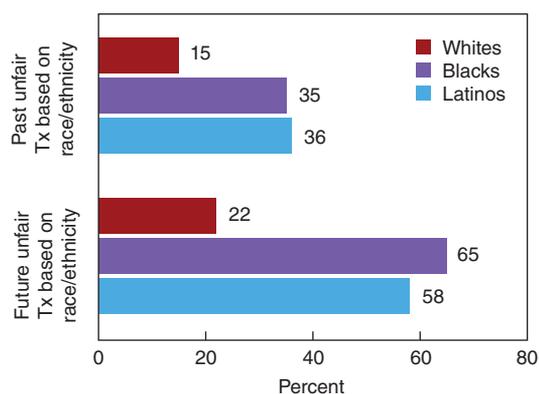


FIGURE 16e-8 Patient perspectives regarding unfair treatment (Tx) based on race/ethnicity. The reference population consisted of 3884 individuals surveyed about how fairly they had been treated in the health care system in the past and how fairly they felt they would be treated in the future on the basis of their race/ethnicity. (From *Race, Ethnicity & Medical Care: A Survey of Public Perceptions and Experiences*. Kaiser Family Foundation, 2005.)

Americans (Hispanics, Asian Americans, Pacific Islanders, Native Americans, and Alaskan Natives). For instance, only in the mid-1980s did the Medicare database begin to collect data on patient groups outside the standard categories of "white," "black," and "other." Federal, private, and state-supported data-collection efforts are scattered and unsystematic, and many health care systems and hospitals still do not collect data on the race, ethnicity, or primary language of enrollees or patients. A survey by Regenstein and Sickler in 2006 found that 78% of 501 U.S. hospitals collected information on race, 50% collected data on ethnicity, and 50% collected data on primary language. However, the information was not collected by standard categories or collection methods and thus was of questionable accuracy. Surveys by America's Health Insurance Plans in 2003 and 2006 showed that the proportion of enrollees in plans that collected race/ethnicity data of some type increased from 54% to 67%; however, the total percentage of plan enrollees whose race/ethnicity and language are recorded is still much lower than these figures.

ENCOURAGEMENT OF THE USE OF EVIDENCE-BASED GUIDELINES AND QUALITY IMPROVEMENT *Unequal Treatment* highlights the subjectivity of clinical decision-making as a potential cause of racial and ethnic disparities in health care by describing how clinicians—despite the existence of well-delineated practice guidelines—may offer (consciously or unconsciously) different diagnostic and therapeutic options to different patients on the basis of their race or ethnicity. Therefore, the widespread adoption and implementation of evidence-based guidelines is a key recommendation in eliminating disparities. For instance, evidence-based guidelines are now available for the management of diabetes, HIV/AIDS, cardiovascular diseases, cancer screening and management, and asthma—all areas where significant disparities exist. As part of ongoing quality-improvement efforts, particular attention should be paid to the implementation of evidence-based guidelines for all patients, regardless of their race and ethnicity.

SUPPORT FOR THE USE OF LANGUAGE INTERPRETATION SERVICES IN THE CLINICAL SETTING As described previously, a lack of efficient and effective interpreter services in a health care system can lead to patient dissatisfaction, to poor comprehension and adherence, and thus to ineffective/lower-quality care for patients with limited English proficiency. *Unequal Treatment's* recommendation to support the use of interpretation services has clear implications for delivery of quality health care by improving doctors' ability to communicate effectively with these patients.

INCREASES IN THE PROPORTION OF UNDERREPRESENTED MINORITIES IN THE HEALTH CARE WORKFORCE Data for 2004 from the Association of American Medical Colleges indicate that, of the 72.4% of U.S. physicians whose race and ethnicity are known, Hispanics make up 2.8%, blacks 3.3%, and Native American and Alaskan Natives 0.3%. Furthermore, U.S. national data show that minorities (excluding Asians) compose just 7.5% of medical school faculty. In addition, minority faculty in 2007 were more likely to be at or below the rank of assistant professor, while whites composed the highest proportion of full professors. Despite representing ~26% of the U.S. population (a number projected to almost double by 2050), minority students are still underrepresented in medical schools. In 2007, matriculants to U.S. medical schools were 7.2% Latino, 6.4% African American, 0.2% Native Hawaiian or Other Pacific Islander, and 0.3% Native American or Alaskan Native. These percentages have decreased or remained the same since 2007. It will be difficult to develop a diverse health-care workforce that can meet the needs of an increasingly diverse population without dramatic changes in the racial and ethnic composition of medical student bodies.

Provider Interventions • INTEGRATION OF CROSS-CULTURAL EDUCATION INTO THE TRAINING OF ALL HEALTH CARE PROFESSIONALS The goal of cross-cultural education is to improve providers' ability to understand, communicate with, and care for patients from diverse backgrounds. Such education focuses on enhancing awareness of sociocultural influences on health beliefs and behaviors and on building skills to facilitate understanding and management of these factors in the medical encounter. Cross-cultural education includes curricula on health care disparities,