

Educational support materials for ABIM's *Care for the Underserved* Module

Module #18

The Institute of Medicine (IOM), in its landmark report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, identified two causes of healthcare disparities: healthcare systems and discrimination at the patient/provider level (defined as 'bias, prejudice, stereotyping, or miscommunication that undermines clinical decision making').(1) Such physician bias may occur subconsciously. Well-meaning individuals may harbor assumptions about people that reflect societal norms. According to social science theory, everyone uses the strategy of social categorization (e.g. by race or gender) in an attempt to understand, predict and control one's environment and process new information.(1,2) Unfortunately, this process can lead to exaggeration of negative inter-group differences (stereotypes) and an over-generalization of them (bias/prejudice).

Healthcare providers may be at increased risk of using stereotypes as cognitive short-cuts because of workplace characteristics (time pressure, high cognitive demand, limited resources and uncertainty) that are associated with the use of unconscious biases. While measuring unconscious bias is challenging, there is evidence that physicians do hold stereotypes based on patient characteristics (e.g. race).(3,4) For example, one study found that physicians were more likely, after controlling for confounding variables, to rate their African-American patients as less educated, less intelligent, more likely to abuse drugs and alcohol, and less likely to adhere to treatment regimens.(5) There are also several studies in cardiovascular care that suggest that physician bias may be an important contributor to disparities in cardiovascular care. For example, Green and colleagues found that physicians who had preferences for white Americans and held stereotypes about black Americans (but who did not report explicit biases), made different treatment recommendations for black patients than for white patients with heart attacks.(3) This unconscious racial bias was associated with more frequent recommendations for thrombolysis in white patients (vs. black patients) with acute myocardial infarctions. Unconscious bias probably contributes to other disparities in care delivered to white and minority patients.(6) Nevertheless, unconscious bias is difficult to study and has not been definitively linked to other wide-spread disparities.

Minority patients receive substantially fewer medical services and interventions during most of their life, despite generally higher incidence of chronic illnesses.(1) In some aspects of end-of-life care, such as pain control, this trend continues.(7) However; at life's end, black and Hispanic patients have substantially higher costs than whites. These increased costs are due not only to geographic, sociodemographic, and morbidity differences, but also to much greater use of life-sustaining interventions.(8) Exactly what contributes to the higher used of life-sustaining interventions is an area of active research.

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While there is no consensus on how to best measure healthcare discrimination, most researchers rely upon patient reports of perceived discrimination rather than measures of physician bias. Self-reported racial discrimination in healthcare has been associated with a range of health outcomes, including less preventive healthcare (e.g. cancer screening, dyslipidemia screening, and influenza vaccinations), prescription medication utilization and medical testing/treatment, and health outcomes (e.g. worse diabetes control).(9,10)

For further information, see the following:

1. Smedley, B.D., Stith, S.Y., & Nelson, A.R., eds. (2002). Unequal treatment: confronting racial and ethnic disparities in health care. In B.D. Smedley, S.Y. Stith, & A.R. Nelson (Eds.), *Institute of Medicine*. Washington, D.C: National Academies Press.
2. Hamilton, D.L. (1981). Cognitive processes in stereotyping and intergroup behavior. (Ed). Hillsdale, NJ: Erlbaum.
3. Green, A.R., Carney, D.R., Pallin, D.J., Ngo, L.H., Raymond, K.L., Iezzoni, L.I., & Banaji, M.R. (2007). Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *J Gen Intern Med*, 22, 1231-1238.
4. Schulman KA, Berlin JA, Harless W, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *N Engl J Med*. 1999;340(8):618-26.
5. van Ryn, M., & Burke, J. (2000). The effect of patient race and socio-economic status on physicians' perceptions of patients. *SocSci Med*, 50, 813-828.
6. Finucane TE, Carrese JA. Racial bias in presentation of cases. *J Gen Intern Med*. 1990;5:120-1.
7. Anderson KO et al. Cancer pain management among underserved minority outpatients: Perceived needs and barriers to optimal control *Cancer* 2002; 94(8) 2295-304.
8. Hanchate A, Kronman AC, Young-Xu Y, Ash AS, Emanuel E. Racial and ethnic differences in end-of-life costs: why do minorities cost more than whites? *Arch Intern Med*, Mar 2009; 169: 493 - 501.
9. Hausmann, L.R.M., Jeong, K., Bost, J.E., & Ibrahim, S.A. (2007). Perceived discrimination in health care and use of preventive health services. *J Gen Intern Med*, 23(10), 1679-1684.
10. Kressin NR. Orner MB. Manze M. Glickman ME. Berlowitz D. Understanding contributors to racial disparities in blood pressure control. *Circulation. Cardiovascular Quality & Outcomes*. 2010;3(2):173-80.

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