



Dr. Mohammed Moinuddin, is director of Nuclear Medicine at Baptist Hospital and Dr. Jaswant Khanna is a psychiatrist with The University of Tennessee. They began work on Disparities in Healthcare four years ago. Their efforts resulted in a series of classes offered to nurses, student nurses and doctors that examined what disparities were and explored why and if they occur. They also authored a paper that was presented at a medical conference in Hawaii examining their experiences with Disparities. Dr. Moinuddin has made presentations to numerous groups including The Downtown Rotary, The Germantown Rotary and individuals from the Indian Community as well as board members of local non-profits. His article was written for Diversity Memphis.

### **Racial Disparities In Health Care**

The subject of racial disparities in health care is a sensitive one. The Institute of Medicine has done an excellent job researching the subject and their book, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” is a landmark document. This book has helped to raise awareness of the problem of disparities in healthcare among organizations such as the American Medical Association, National Institutes of Health and the American College of Physicians. However, despite the attention; this problem remains pervasive in all fields of healthcare.

In the 1930’s the racial tension in the United States prompted the Carnegie Corporation to invite a noted sociologist, Professor Gunnar Myrdal, to come study racism in the US. Myrdal, a professor at University of Stockholm, was chosen because it was believed that a foreigner would be able to give a more objective report. After traveling throughout the country, Myrdal published his findings in a book entitled “American Dilemma.” One of the chapters of the book specifically addressed the issue of health care. In this chapter Myrdal says, “Area for area, class for class, Negroes cannot get the same advantage in the way of prevention and care of disease that whites can. Discrimination increases Negro sickness and death both directly and indirectly, and manifests itself, both consciously and subconsciously.”

Although Myrdal’s work brought the problem of racial disparities in health care to the attention of the public, it has taken six more decades and the publication of hundreds of articles for the government of the United States to request official research on the topic. In 1999 Congress requested that the Institute of Medicine (IOM) specifically investigate three issues. First, how socioeconomic status and culture influence access to health care. Second, evaluate the sources of bias, discrimination and stereotyping. Third, make recommendations about how to solve the problems of these disparities.

The Institute of Medicine reported that in many areas of healthcare African Americans and other minorities receive less aggressive treatment than their white counterparts. For example, heart disease is the number one cause of death in the United States. The IOM Commission found that African Americans with chest pain were less likely to undergo

invasive diagnostic procedures than whites. When they did receive such diagnostic care, it was found that they were less likely to receive aggressive surgical or drug therapies as treatment. Another example is found in the treatment of kidney disease. African Americans were found to be not only less likely to receive a transplant, but less likely to be put on a waiting list. When they were on a waiting list they had a longer wait period than whites. In the treatment of cancer disparities were also found. African American women were less likely to receive screening mammograms than white women and treatment for colorectal cancer was found to be less aggressive in African Americans than it is in whites.

Despite the disparities found during the IOM report, all hope is not to be lost. Changes have been seen and improvements have been made. For instance, the gap between screening mammograms in the 1990's has been corrected and is now equal. This is not to say, however, that there are not problems remaining to be addressed. In the 1950's the overall mortality rate among African Americans was 60% higher than among whites. This number had not changed as of 1995. In many areas of healthcare African Americans continue to receive a poorer quality of care and less aggressive treatment.

The IOM made several recommendations that must be instituted to help close the gap in health care. First, health care workers and the public need to be educated about the causes of racial disparities. Second, insurance plans need to be designed in such a way that all people receive equal health care. Third, more minorities need to enter the health care profession. Fourth, healthcare workers need to be taught about the cultural differences that may influence the attitudes and reactions of patients. Fifth, more interpreters are needed to ensure that English speaking health care providers and non-English speaking patients can communicate accurately. Finally, the commission recommended that the research into the problem of racial disparities in health care be continued so that further recommendations and solutions can be made.

Diversity Memphis offers a program that directly works to help educate and inform health care providers about racial disparities in health care. In our work we have seen that although people may at first not understand or believe that there is a problem, continued discussion and presentation of facts tend to alter beliefs. Education is the first step toward eliminating racial disparities in health care and ensuring individuals of all races receive excellent medical care.

For more information and a presentation regarding Disparities in Healthcare, please contact the Diversity Memphis office at 405.9555 or Dr. Mohammed Moinuddin at [moin39@msn.com](mailto:moin39@msn.com).