

CORRESPONDENCE



Primary Care Physicians Who Treat Blacks and Whites

TO THE EDITOR: Bach et al. (Aug. 5 issue)¹ present disturbing evidence on disparities in the training of physicians who treat black patients and those who treat white patients and in access to high-quality care by black patients and white patients. The reason these differences occur is important, because it bears on how best to rectify an unacceptable situation.

One possibility is that patients with higher incomes see better-trained physicians and have better access to high-quality care than do patients with lower incomes, but that when whites and blacks have similar incomes, black patients are not disadvantaged. This finding would not render race-based differences in access benign, nor would it be a sign of differential treatment according to race within the medical sector. Rather, it would highlight one of the many reasons why it is important to reduce economic disparities.

Another possibility is that even if one controls for income, blacks have poorer access to well-trained physicians and high-quality care than do whites. That finding would be even more disturbing. Can the authors shed light on whether the disparities result from income inequality only or from inequality plus race?

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1. Bach PB, Pham HH, Schrag D, Tate RC, Hargraves JL. Primary care physicians who treat blacks and whites. *N Engl J Med* 2004;351:575-84.

TO THE EDITOR: The article by Bach et al. is an important contribution to the literature on health care disparities because it empirically demonstrates that a health care system fashioned by the marketplace leads to inequitable distribution of resources. Yet the study has the potential of doing harm if physicians find its conclusions, in the words of the accompanying editorial, “both reassuring and disturbing.”¹ That inequities in the distribution of resources partly explain disparities in health care outcomes is undoubtedly true. This study, however, does not invalidate the large number of studies conducted in closed systems (such as the Department of Veterans Affairs² or staff-model health maintenance organizations³) or single institutions⁴ that show that black patients receiving care within the same system — with the same resources and physicians — as their white counterparts can and do receive inferior care. Interpersonal bias is a consequence of the structural inequities described by Bach et al., and yet bias itself partly explains our society’s tolerance of these inequities. These are not competing hypotheses; rather, they reinforce each other. Policies to address racial disparities in health care should address both structural and interpersonal causes.

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THIS WEEK’S LETTERS

- 2126 Primary Care Physicians Who Treat Blacks and Whites
- 2128 High versus Low PEEP in ARDS
- 2129 Venom Immunotherapy
- 2131 Aldosterone Revisited
- 2133 Deep-Vein Thrombosis
- 2134 Oligospermia in a Patient Receiving Imatinib Therapy for the Hypereosinophilic Syndrome

1. Epstein AM. Health care in America — still too separate, not yet equal. *N Engl J Med* 2004;351:603-5.
2. Petersen LA, Wright SM, Peterson ED, Daley J. Impact of race on cardiac care and outcomes in veterans with acute myocardial infarction. *Med Care* 2002;40:Suppl:1-86-1-96.
3. Schneider EC, Cleary PD, Zaslavsky AM, Epstein AM. Racial disparity in influenza vaccination: does managed care narrow the gap between African Americans and whites? *JAMA* 2001;286:1455-60.
4. Peterson ED, Shaw LK, DeLong ER, Pryor DB, Califf RM, Mark DB. Racial variation in the use of coronary-revascularization procedures: are the differences real? Do they matter? *N Engl J Med* 1997;336:480-6.

TO THE EDITOR: Rather than impugn the abilities of the small fraction of physicians who treat black patients, the results of the study by Bach and colleagues demand that we question the integrity of the majority of doctors — board eligible or not — who do not treat black patients and the system that tacitly endorses segregated health care.

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THE AUTHORS REPLY: Aaron asks whether our findings may be more closely linked to differences in the income of patients than race. As we reported, adjustment for the median income in the ZIP Code of either the physician's practice or the patient's residence did not alter our findings. However, ZIP Code-based estimates are imperfect surrogates for measures at the individual level, and as a consequence, we have probably underestimated the importance of the patients' socioeconomic status.¹ If socioeconomic status partially explains our findings, we concur that this would not negate the importance of racial disparities in the quality of health care but, rather, would broaden the scope of likely explanations.

Fernandez and Goldstein echo the belief of many that interpersonal bias, manifested by differential treatment of black patients and white patients by individual physicians, is at the root of health care disparities.² Our study, by presenting evidence that black patients and white patients are usually treated by different populations of physicians who have different qualifications and health care resources, raises some doubts about the primacy of the interpersonal-bias explanation. To determine the magnitude of the contribution of physician bias to health care disparities, which our study did not address, investigators must determine whether individual physicians actually treat their black patients and

white patients differently. In none of the landmark studies cited by Fernandez and Goldstein is it likely that the black patients and white patients were treated by the same physicians in equal proportions,^{3,4} and in the case of the single-center study from Peterson et al., the authors specifically report a difference between the black patients and white patients and the medical services through which they were treated.⁵ More to the point, in none of these studies did the authors conclude that interpersonal bias was responsible for the findings.

We appreciate Wheeler's frustration at what appears to be segregation in the health care system. However, our data do not support the conclusion that physicians are responsible. We demonstrated that most primary care physicians in the United States see relatively few black patients, but we have no evidence that this reflects a choice by the physicians. Rather, the distribution of black patients among physicians appears to be largely a result of where black patients and white patients live. More generally, our results suggest that some underlying causes of disparities may not be under the control of individual physicians at all — if, for example, the resources available to physicians differ systematically between geographic areas. On a minor point, we showed that physicians who treat black patients are less likely to be board certified than are physicians who treat white patients. We did not examine board eligibility.

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1. Bach PB, Guadagnoli E, Schrag D, Schussler N, Warren JL. Patient demographic and socioeconomic characteristics in the SEER-Medicare database applications and limitations. *Med Care* 2002;40:Suppl:IV-19-IV-25.
2. Smedley BD, Stith AY, Nelson AR, eds. *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington, D.C.: National Academy Press, 2003.
3. Schneider EC, Cleary PD, Zaslavsky AM, Epstein AM. Racial disparity in influenza vaccination: does managed care narrow the gap between African Americans and whites? *JAMA* 2001;286:1455-60.
4. Petersen LA, Wright SM, Peterson ED, Daley J. Impact of race on cardiac care and outcomes in veterans with acute myocardial infarction. *Med Care* 2002;40:Suppl:1-86-1-96.
5. Peterson ED, Shaw LK, DeLong ER, Pryor DB, Califf RM, Mark DB. Racial variation in the use of coronary-revascularization procedures: are the differences real? Do they matter? *N Engl J Med* 1997;336:480-6.