
A Physician's Perspective on Minority Health

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In this article, the author discusses her many and varied experiences with health care provision. Her insights into the many dimensions of disparity in health care lead to a set of recommendations for further research.

INTRODUCTION

I have been a health care provider for 35 years, both as a nurse and a physician. Most of my work has been in the field of medical-surgical direct patient care, clinical medicine, and, at one point, psychiatric medicine. My work has been constant and consistent in direct patient care. My experience is in community-based clinics, tertiary health care centers, old and new public and private hospitals, private residential centers for the mentally ill, and nursing homes. I have also provided care in small town hospitals, private practice offices, military and veteran hospitals, prison health care clinics, centers for the developmentally disabled, emergency departments, rehabilitation hospitals, State hospital facilities, tropical health clinics, and home visits. I have cared for patients of all ages and many languages. I have cared for black, Hispanic, Asian, African, European, and Native American people. I speak two languages.

In early years, the folks I loved, worked with, grew up with, and lived next door to were chronically ill or died. They had strokes, heart attacks, cancer, and diabetes. They did drugs, their babies died for "God knows why," and often, they were

violent. Many were in their 40th or 50th years or younger when they died. As a young girl, I remember that, when someone commented on the fact that "they were so young when they died," the answer was always, "God in his own time, baby girl." An acceptance and reverence for the cruel reality of early death was pervasive throughout my working-class community.

At the time, I had no idea that the residents of other parts of the same city were living longer and that disease was not taking them from their loved ones and their work nearly as early. As I grew older and joined the health profession as a nurse, I viewed disease in the narrow context of molecular pathology, rather than with a public health orientation. I did not understand, nor was I taught, that disparity was all around me. I did notice, however, that minority patients were sicker when they got to the hospital, their hospital stays were often much more tumultuous and difficult than those of white patients, and the followup after discharge was often less than adequate.

Over time, I began to understand the magnitude of the disparity between the health of the minority population and the majority population. This entire article could explore the differences in health indicators between white people and minority populations. Instead, there is a dimension of this problem that feels equally important to me, as a physician. Health care providers have been aware of the disparity to some degree for years and have been in the difficult, almost arrogant, position of attempting to reduce it without the information needed to have an impact. It is that dimension I will address here.

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There is virtually no public awareness of this problem, even after a recent Kaiser survey (1999) found that the quality of health care delivery is negatively influenced by the patient's race and ethnicity. The Health Care Financing Administration and other agencies concerned with quality of care and oversight can assist in expanding the potential impact of the health care provider by raising the awareness of these problems to the public, thereby helping to eliminate them.

This article uses my newly invented term: "cultural disregard." Cultural disregard is defined for the purposes of this article as a lack of insight into the social dynamics and unique struggles of minority populations. Gracefully put, cultural disregard is "not knowing what one does not know." Cultural disregard is expressed in statements such as "We're doing everything we can for them and they still don't seem to understand." At a minimum, it is the negative feeling toward a patient by health care providers because of the patient's apparent lack of cooperation and lack of compliance. At its worst, cultural disregard manifests as blatant racism in the health care delivery system. Aside from the ethical divide racism creates, it is not cost-efficient in that it leaves the patient only appearing to receive adequate health care.

To make research have a greater impact, there is a need to address several major areas. In this article, I focus on two: (1) how patients, providers, and the health care system interact, and (2) how we provide effective services to patients and learn from the provision of those services.

INTERACTION OF PATIENTS, PROVIDERS, AND SYSTEMS

Many factors affect interactions between patients, providers, and the health care system. These include prior experiences,

communication, and assumptions, among others. Various racial and ethnic groups have had different historical and personal experiences, different language and education barriers, and different knowledge levels about standard health interventions and the health care system. All of these factors affect patients and providers and their working relationships.

If experiences, communication gaps, and prior assumptions affect the quality of the relationship between a patient and a provider, or if they affect a patient's ability to interact willingly and productively with the health care system, health outcomes will be affected.

Historical, Family, and Personal Experiences

Certain racial and ethnic groups have had notable historical experiences that have served to change their picture of the health care system. The most notorious of these is the Tuskegee University study, paid for by the U.S. Government, which observed black men with syphilis in order to study long-term complications of the disease; study participants believed they were being treated. The fact that there is intergenerational transmission of stories about health care experiences and attitudes toward the health care system is important. What happened yesterday affects what happens today, and what happened to the grandparents can affect health care attitudes far into the future. The manner in which this attitude is transmitted is different for different racial and ethnic groups; some will have longer intergenerational memory than others.

There is also intergenerational verbal transmission of information on health and healing. Taking care of or preventing certain conditions often involves the use of alternative or "folk" medicine in the minority community.

Role of History

Researching the effects of the history of minority health care delivery on the choices and decisions made by minority populations today will be enlightening and worthwhile. The levels of disenfranchisement experienced by elderly minority patients who are communicating with our youth may be playing a significant and subtle role in the issues of access to care and compliance. Many of these older people would not be admitted to the hospital and no doctor would see them when they were young. They had to learn how to intervene medically for themselves and their families; often with a patient outcome of a bittersweet, long-term, compromising handicap, albeit lifesaving treatment for the injured or infirm.

For example, my uncle, age 80 and living in the deep South, was kicked in the leg by a horse when he was 9 years of age; we later learned that it shattered his hip, leg, and knee. No doctors or hospitals would treat black people, and so my grandmother kept my uncle bedridden and “massaged” his leg and hip back to health. Uncle Lawrence walked with a limp that bent him 90 degrees with each painful step. He never was able to have children. He worked in the fields his entire life. He had a wonderful laugh and thought we were being silly when we expressed concern about his care. He used to discount our upset by saying, with music in his voice, “Who can take better care of you than your momma?”

We know that intergenerational “chat-ter” can have positive effects on health within families. The choices made by families across this country are often based on the health care they received and the care of their ancestors before them. Older physicians are often the physician of choice for families that have enjoyed good health for years. The fondness for and ded-

ication to providers who have taken care of generations of children in one family are often galvanizing in their intensity.

Conversely, negative experiences in health care delivery also play a role among the generations. Minority patients have endured a range of negative experiences. Hospital stays were fraught with operational adjustments because of their race. There were nurses who transferred care to minority providers because the nurses “didn’t feel comfortable with them.” There were personal indignities, such as being moved in their hospital beds into the hallway with a wrap-around screen for privacy if a white patient was admitted to the room. There were racist policies, such as having to enter the hospital by separate doors in the back of the building or not even being allowed into the hospital as late as the 1960s.

I remember a very proud, elderly, dark-skinned lady who signed herself out of the hospital because the doctor refused to address her by her last name when she asked him to. I heard him tell her that it was a hospital rule that he was following by calling her by her first name. She was not readmitted when the family brought her back because she referred to the doctor by his first name. Nothing anyone said to her could make her stay in the hospital.

It never occurs to some patients to ask questions of the physician. Years ago, minority patients spoke of and to the physician as if he were a god. (From some of the stories I believe a few were.) Although illiterate, these patients signed consent forms without a clue as to what procedure would be done. In general, many of the doctors spoke the language of medicine, which the patients did not understand. Minority patients have often stated to me that they did not want to make the doctor angry because then he might do something that would extend their stay in the hospital. They usually knew no one who knew or had

heard of the doctor before their visit. Often, they did not know the doctor's name and identified him only by a physical description. Minority patients often had no concept of the reason they had surgery or were hospitalized. Any explanation was lost on them, usually because of the manner and speed with which it was usually explained. There are families with countless members who have never reproduced, and they have no idea why.

Today, we are sure that these negative perceptions are relayed, directly or indirectly, to the daughter or great-granddaughter of age 16 with whom the elder lives. That young woman may be pregnant and making life decisions about prenatal care, screenings, and health maintenance. Her unhealthy decisions will be made with a negative intergenerational influence, in the same manner that the families with positive experience in health care discussions have made their positive decisions.

Role of Cultural Disregard in Research

My experience has been that some Federal agencies have such long histories with certain universities and research centers that it is assumed that all major research, whether minority-oriented or not, should be focused into these dependable, albeit often elitist, institutions. It is clear that resources for research are limited and accountability is essential. These institutions that have been funded have proven to be responsible and academically and operationally qualified to do the work. There have been substantial efforts by such institutions as the National Institutes of Health (NIH) to refocus some of the research dollars. The reality, however, is that, everything being relative, very few dollars go to minority researchers at NIH or other institutions across the board.

Another, equally important reality is that there are a myriad of minority researchers who have been rigorously trained in accredited schools and who are working in minority research centers who deserve and are eminently qualified to receive initial, rather than secondary, funds for research.

I have attended research reviews in Federal and private settings and have found very subtle and important differences in the way this research would have been done in a minority institution. For example, I attended a review of the research performed by a white researcher in an urban minority school. His research involved asking parents questions, and he only interviewed mothers and did not include fathers. When asked why, he stated that he didn't think that even asking about the fathers was important because "fatherhood is not a strength in the target neighborhood."

Role of Alternative Medicine

Many of my patients and family members have spoken of using potions and other medically oriented interventions before going to visit a health care provider. I have begun to ask patients whether they are using other forms of healing when I do a history and physical. My mom fell on her knee recently, and it did not heal with the antibiotic ointment that I gave her. She gave up on my therapy, grabbed the sugar bowl, and daily poured sugar onto her knee. The wound healed by granulation with minimal scarring and in record time. After I expressed amazement, she began to describe other alternative therapies she has used or seen used over time. She talked about her sister being burned years ago—no doctor or hospital would see her because she was a black patient. Her mother collected gray spider webs every

day from the ceiling of the barn and placed them on her wounds. As her sister and my mother recall, her burns healed with very little scarring and no infection.

Minority patients have used alternative medicine for many years. Most could not get care within the system and had to search for cures outside of the system. Many of the elderly who are knowledgeable about alternative medicine are experts because they had to learn how to save their families when no one would care for them. When we combine that with the suffering and exposure they endured, it is clear that there are untouched strengths in the culture of alternative medicine that should be explored and documented. Some of the oldest remedies have even been recorded, and old and young patients go to these books for enlightenment.

Many of those who practice alternative medicine are still able to influence health care in their families. It is important to remember that alternative medicine choices are often instituted prior to a visit to the allopathic provider.

Role of Communication

An inability to discuss or discomfort with discussing health issues in English with a patient with a different native tongue can be an obvious communication barrier that may perpetuate racial/ethnic disparities in health care. However, there are other communication issues that also play a role. If patients speak English well but are unfamiliar with medical terminology, basic anatomy/physiology, and behaviors that affect their health and health care, doctors may just as well be speaking another language when they use technical terms to provide patients with explanations or instructions. Minority patients, once made

aware of the health problems inherent in the disparity in a language they understand, are willing and able to introduce preventive initiatives into the community.

Although to some providers it may appear that minority patients do not care about their health or that of their children, most responsible providers understand that minority patients do not want their loved ones to become ill, especially with a preventable disease. It is therefore imperative that the roles of social communication and marketing of health and the role of health literacy be packaged together and researched for their combined rather than separate effectiveness. The effects of toxic waste, the marketing of cigarettes to minority communities, and the biological and physiological effects of fast foods must be translated from medical language into a language of health promotion and disease prevention that minority populations can use. With no disrespect intended to health care providers, I remind them of the story of Mark Twain going to Paris where he says, "I spoke French the whole time I was there. I never did get those idiots to understand their own language."

There are many examples of language difficulties that can be addressed to reduce barriers to communication. For example, we could redefine the word "normal" in terms of what people typically experience. Suppose, for a moment, that a cluster of young teenagers from the same neighborhood all deliver in the same hospital. Most of the babies have low birthweight and therefore stay in the isolette for days or weeks. After gaining weight for a month or two, the newborns are sent home with their young parents. If that happens to almost every child in that neighborhood, young parents see this pattern as normal, just like 10 fingers, 10 toes, 2 eyes, a nose,

and a mouth. Providers often miss this difference in perception and assume that the word "normal" means the same thing to both provider and patient.

The marketing of health care has been an important element in the effort to reduce disparity. The most notable form is advertising, for example, the anti-smoking message on the side of cigarette packs. It reads: "If you smoke while you are pregnant, you could cause fetal damage." Again, it is imperative to change the wording to something that is better understood by the youngest among us who is pregnant. How many children of age 14 use and understand the word "fetal"?

The warning on the side of a cigarette pack also states that smoking could cause low birthweight. That language, too, is a problem for those not familiar with the medical implications of the term. Low birthweight is "a good thing," to quote one patient, "because a big baby hurts when it comes out." Using the medical term "low birthweight" on the pack lessens the impact of the true meaning of low birthweight, which covers six pages in my obstetrics and gynecology textbook.

Assumptions Brought to Health Care Encounters

Patients and providers both bring a set of assumptions, views, and expectations to their encounters. These include patients' assumptions and expectations about what providers can do for them, how providers will behave toward them, and what providers understand about the patients' health. On occasion, providers bring assumptions and expectations about what previous patients "like this one" have been like and how those patients have understood and complied with explanations and instructions.

One example of assumptions about behavior can be found in the billing practices of some physician groups that, when billing minority patients, always added costs to the bill for lateness. Another, more clinical, example is that of a young obstetrician who did not report to the police the obvious sexual activity of a black girl of 13 years who for years had been abused by her father. In testimony, the physician stated that he did not report her because "she didn't look any different than all the other 13-year-old black girls in this neighborhood."

There are many indicators that failure to adhere to treatment protocols or non-compliance is not an issue of active resistance or apathy about one's physical health. It is, rather, a manifestation of the degree to which the intervention is misunderstood, invokes fear, or is believed to be painful. Much of this understanding is affected by the quality of the interaction between patient and provider. A provider whose attitude is one of taking responsibility for his or her role in the actions of the patient in carrying out the patient's prescribed regimen is associated with a notable level of compliance. Adherence is based on the communication skills of the provider. Studies have shown that many minority patients do not feel that their provider cares about the outcome of their disease.

A bottom line with patients is that no one wants to be sick. If patients hesitate in following a therapeutic regimen it is because of a deficit in communication that must be corrected. Compliance demands communication that works toward wellness.

Changing the Paradigm

Watching a minority male or female shop in a store is quite a different experience from watching them visit a physician. The

difference lies in the attitude, tolerance, and demands that are placed on the retailer by the shopper. There is a feeling of power that is demonstrated by the minority customer that is not seen in the same minority patient visiting a physician. In the shopping situation, the minority consumer asks appropriate questions, examines merchandise, checks to ensure that the product is perfect, and insists on understanding how the product works and the dangers of its use.

In direct contrast, the minority patient often presents as a quiet, passive, almost removed individual, who seems grateful to be in the presence of the provider. At best, the patient answers all questions, offers little conversation, and nods compliance with each suggestion. At worst, the patient stares straight ahead, frightened and intimidated by the surroundings. It should be noted that the difference in this presentation of the minority patient is not necessarily restricted to the provider/minority patient scenario.

Factors that influence patient behavior in the provider's office include embarrassment, a position of power for the provider, health illiteracy, self-esteem issues, self-perceived "intelligence" factor, and language differences. For all of the barriers and regardless of the causes, improving communication between the provider and the patient will go a long way toward alleviating the factors that cause patients to behave in a non-assertive way. The assertiveness that a minority person brings to the shopping experience could be used as a model for behavior that is useful and necessary in the physician's office.

It is possible, but not certain, that the patient who is of the same ethnicity and race as his or her provider will have better outcomes because of better communication. Patients who understand their physicians and feel understood are more likely to comply with their instructions and gain

an awareness of their own health status. Conversely, the question of the role of the non-minority provider and the level of compliance, enthusiasm, communication, etc., should be explored. It is this author's belief that the cultural background of the provider is of little importance. The level of caring one is able to express for the patient and his or her well-being is of prime importance.

IDENTIFYING UNMET NEED

We know a great deal about how to provide effective, cost-efficient, clinical and preventive services. We still do not know much about how to provide them in a way that helps reduce racial and ethnic disparities. The recommendations from this section are less concerned with direct patient care and more focused on the environment in which the patient lives and works.

Some racial/ethnic groups are disproportionately affected by substance abuse, violence, and injury. Among other places, hospitals, emergency departments, emergency medical services (EMS), and medical examiner's offices are where evidence of these disparities is likely to be manifest. The data we find there is often surprising. For example, emergencies may have underlying causes that are not obvious at first. Deaths may be from known causes, but autopsies may reveal information about other, previously unknown health conditions that are related to disparity. The information we uncover will help us learn more about how to eliminate racial/ethnic disparities in health.

Hospital and Emergency Services

Statistical data are one important part of the overall interpretation of the health status of minority patients in this country. When we review the statistics and trends

in the health status of minorities, the numbers reflect minimal improvement over time. Information that is skewed or blatantly incorrect may play a part in this lack of improvement or in our determination of how to prioritize our interventions. For example, a city's funding for substance abuse prevention is determined, in part, by the number of overdoses that occur over a specific period of time. To maximize the treatment of recovering addicts, those numbers should be accurate. We have been able to identify a more expansive data base that reflects a different reality than what has been heretofore reported.

While serving as a medical officer for the Washington, DC, Emergency Ambulance Bureau, I collected data each morning on the drug overdoses from the previous 24 hours. Some of the overdoses were from cocaine or crack, and patients were taken to the emergency department for medical intervention. The overwhelming majority of the overdose encounters, however, were due to heroin; patients were most often found lying on the ground, unconscious, and often in respiratory arrest. The citizens' calls for help to 911 identified the location of patients in homes, in alleys, on public transportation, and in shelters. The treatment of choice in these situations is to administer oxygen and the medication Narcan (naloxone), which is given intravenously to reverse the symptoms of the heroin overdose. Narcan competes with heroin for receptor sites and reverses the symptoms of the overdose in minutes. Often, the providers document that the patient awakens, looks around, stands up, and walks away, disgruntled because the provider has interfered with the heroin "high." Most of the time, the recovery from the overdose is so complete that the patient refuses to be transported to the emergency department.

Although providers usually obtain vital information during encounters in order to document the care given, (including patient name and other identifiers), the information is not passed on to any health care facility. The vast majority of these patients during a 24-hour period are minority men and women. We decided to enhance our knowledge about the data by creating a coalition with the administrator of our drug treatment facility. When asked to review the names of the patients who overdosed against the names of the patients in treatment for substance abuse, the director of the local abuse treatment program was able to identify most of the overdose patients as active participants. To protect patient privacy, that information was never formally relayed to the system; however, outreach and followup programs were intensified. The data, however, remain in the data bank of the emergency ambulance system.

The statistics also lead to an obvious disparity between the actual and reported numbers of patients who overdose. For example, during a 1-month period in the District of Columbia, there were approximately 250 overdoses from heroin alone. The official reporting system, which measures overdoses quarterly, reported 157 overdoses during a 3-month period, including the month described. It should be noted that, because it is possible for this gross disparity to exist for extended periods of time with no correction, we should be anxious to review all data that influence the funding of programs associated with reducing the health disparity.

Data Collection for Emergency Medical Services

EMS providers can offer information that describes the patterns of health and disease on a geographically specific, time- and

date-specific basis. This information, when reviewed by the providers within communities that are dealing with the disparity issue, can prove essential to the outreach and treatment of disease in that community.

Problems of substance abuse, intentional and unintentional injuries, teenage pregnancy, infant mortality, and medical and surgical emergencies can be accurately assessed by a steady and complete review of the emergency care provided in a community. For example, as the medical officer of the Washington, DC, Emergency Ambulance Bureau, every afternoon I reviewed the individual documentation for each emergency provider team. One example of a series of data collection sessions was the separation out of emergency calls made by pregnant women. This session revealed which areas of the city had the most pregnant, substance-abusing women who were reacting to drugs and/or being physically abused. I also devised a method of collecting data that revealed the place and frequency of prenatal visits by pregnant women. This allowed for targeted outreach into the community and, over time, an increased awareness of the problem of abuse among pregnant women.

Medical Examiner's Office

While working in the Washington, DC, Medical Examiner's Office, a number of issues surfaced that could have an impact on present prevention initiatives. During the mid-1980s, there were at least 30 homicides a month of minority male youths between the ages of 11 and 23, most of whom were killed with bullets or knives. The cadavers were healthy-looking, young black and Hispanic men with big muscles, perfect haircuts, and smooth skin. Many were under the age of 16. Because there has been no war on our land for many years, this was probably the only period of

time in our history when the bodies of young men were exposed to the medical community through autopsy. During the autopsies, it became evident that some of the youths were living with clinically significant, previously undetected diseases. There were cases of bilateral pleural adhesions and pleural thickening, left ventricular hypertrophy, white cell hyperplasia, and congenital anomalies such as horseshoe kidneys. We assume from records and from the families' statements that none of the diseases were being treated despite the fact that some had progressed to the point of obvious clinical compromise. Perhaps the most significant finding, and clearly the most common in these young men, was the presence of varying amounts of thick, yellow plaque on the large vessels.

These data could be researched for the implications regarding diet and cardiac disease. In conjunction with a nutrition initiative and an intense education program, adults and youth could use this information to begin a better diet and a more responsible health maintenance effort.

Frequently, there are cases where the person is actively doing drugs just prior to death and, in an apparent conflict, is shot in the head. The blood from the cadaver is sent to the toxicology laboratory, where it is determined that a lethal level of an illegal drug in his system caused the death. Within hours, the pathologist determines that the bullet hole in the same cadaver is the cause of death.

Prevention and Counseling Initiatives

The issue of prevention education is a demanding one in that it requires that the educator have a strong sense of the target audience before even beginning to teach. The subject of health is a personal one, replete with anecdotes that reveal massive differences among and within cultures. In

an attempt to resolve what those differences are, it is vital to reach out, ask questions, and take notes. Focus groups can assist us in moving beyond what we perceive to be a problem to what the actual problem is and how to fix it. Groups that are most in need of prevention are often the very same groups with language problems, cultural differences, and other, more pressing, priorities.

Prevention Programs

The issue of early intervention in growth and development of our youth has taken hold. Government agencies across the board agree and are funding programs that create healthy starts and safe kids. Pediatricians giving physical exams are required to screen patients for physical or developmental problems from the very first examination. The Early and Periodic Screening, Diagnostic, and Testing (EPSDT) program was started to assist physicians in detecting problems early so that their long-term effect and cost for treatment would be minimal. At the same time, many of the parents who bring children for these periodic exams are not long out of EPSDT examinations themselves. The combination of the increase in teenage pregnancy and the disparity issue, coupled with communication issues and health-literacy problems, makes it imperative that pediatricians be given the time and latitude to expand developmental screenings during clinical visits. The extra time would allow for a detailed developmental history that could determine whether early intervention is necessary. When I ask many young people about the part of the screening examination for developmental problems that involves them directly, through questions and answers, they say that the examination is often cursory, consisting of one yes or no question about the baby's

growth and development. If the answer is essentially normal, the provider moves on to other issues. Gross abnormalities, however, are treated right away, with a plethora of referrals to specialists.

It will be important, in reducing disparity, to begin to treat growth and development abnormalities, no matter how subtle, early and aggressively. Referral centers are already set up. Because the issue of growth and development (beyond the physical norms) is not the prowess of the allopathic physician, it may be prudent to have the complete developmental screening done by an assessment center. If further treatment is required, it has been provided for through public law. Although health care providers are not specialized in that area, there are health team members who are. They should be attendant at the patient's history and physical and allowed to manage the cases of the children found to be even mildly compromised.

Explore the Effects of Good Health Habits

Most of the minority population have good health habits and have not been exposed to or had to deal with the problems of abuse, neglect, violence, drugs, poverty, etc. Lessons in health care and maintenance are important to them, risk-taking is minimized, and the physical standard by which they live exceeds that of many of their fellow citizens. It would be useful to explore how to introduce their habits into communities where there is a need. Populations with low-risk health habits interacting with populations with high-risk behavior is not uncommon in minority communities. Communities of color are made up of a myriad of social strata that often come together for prolonged, regular, consistent interactions. Families, replete with social stratum variances, are one of the first

and most important institutions that illustrate the overlap between individuals. Spiritual centers easily and with little strain mix social strata regularly. In the case of the Asian population, for example, first-generation Asians spend quality time teaching new immigrants to wash their hands and clean their personal items.

Recently a friend of mine from Africa remodeled her home there after learning about the revulsion and disease associated with the house fly. There is a need for such interaction above and beyond the health educators and others who are paid to teach our communities about avoidance of high-risk behavior. Such interaction should include children who return to the community after being out-placed from it for extended periods of time and adults who have progressed to a new socioeconomic level and who continue to support, be with, and care about the welfare of the high-risk population from which they moved away.

CONCLUSION

The thoughts and suggestions expressed in this article are based on three premises and one potential bottom line with which I continue to wrestle. The first premise is that patients do not want to be sick. All patients want to be well and happy, free of pain, and independent. The second is that providers are well-meaning, ethical, and dedicated professionals who, under the best of circumstances, are stellar in the care of their patients. They want to do it right. The third is that health care research is vital to the delivery of responsible health care to the patient and to our communities. Researchers inform providers about the patient beyond the feel and the sounds of the patient and into the realm of the larger picture that affects the public health of this Nation. The bottom line with which I continue to wrestle is that

success as a provider or as a researcher does not yet translate into or, at times, even influence the good health of many of the people they serve. There are disconnects. There is confusion. And there are barriers.

This article provides an “underbelly” view of a small part of the foundation upon which the system sits. The faces that have been described anecdotally are the same patients who visit clinics all over this country every day. What we are depicting is the embodiment of the quote: “the plural of anecdote is data.” The repair of some of the connection problems and the reduction of some of the confusion, even the recognition of some of the barriers, has been my intention. I am a strong proponent of focus groups based on the idea that we think we know and then we listen and find that we know very little about the way that health unfolds inside the homes of our patients. There is more to write to offer new directions for providers and researchers. Much of it must be said away from the graphs and numbers, always with much respect for the role of data in raising our awareness of the many dimensions of this issue.

This article is in a quiet corner, at once offering relief from the health statistics that seem to control many of our thoughts and using those research statistics to broaden the scope of how we must think about our delivery of care. There must be a face on all of this and this article has tried to show it to the reader. I have no doubt that there is great brilliance among us, combined with a dedication that is almost palpable. New directions will offer us a way to enhance and then transfer our intellectual capital into the lives of each and every patient we influence. The graphs will change, then. The scope will be broader. The work of reducing and eliminating disparity will require a level of expansion into new research dimensions that is unparalleled in our history.

Recommendations for Research

1. Study the effects and influences of history on the behavior, choices, and decisions made by younger minority patients.
2. Explore the role and long-term effects of cultural disregard (as previously defined) in fostering health disparities. Use minority researchers whenever possible to obtain this perspective.
3. Compare the affordability and effectiveness of alternative therapies and examine the willingness of patients to pay for these.
4. Examine the role of language in health disparities and identify vocabulary that will convey the desired meaning to a target group.
5. Use compliance levels among patients to assess the effectiveness of patient-provider communication.
6. Examine the extent to which "profiling" of patients affects patient encounters and influences the standard of care provided.
7. Study why patients behave with assertiveness in some situations and not in others. Determine how to bring this assertive attitude to provider encounters.
8. Assess the impact of matched racial/ethnic background on patient-provider interactions. Determine the importance of the level of caring in health care delivery.
9. Examine the effects of inaccurate data and the effect on disparity. Include in this study the impact of inaccuracies on funding for health programs.
10. Use EMS data to establish a knowledge base about injury and illness among target populations.
11. Determine the accuracy of data regarding drug abuse, homicide, and suicide. Assess the impact of any inaccuracy on funding for these problems.
12. Study the feasibility and cost-effectiveness of having providers dedicated to the ongoing assessment of growth and development in children. Coordinate care between these providers and physicians to screen for disability and obtain treatment for children as early as possible, using already-funded programs.
13. Study the role and influence of minority patients' low-risk health behaviors on minority patients' high-risk behaviors. Ascertain what approaches and types of communication are effective in having an impact on behavior.
14. Examine the role of inaccurate or skewed data on long-term cost estimates, policy decisions, and outcome studies.
15. Study EMS data to identify areas of illness and injury and develop targeted interventions.

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