Health and Medical Care

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THE MEDICAL ESTABLISHMENT is strongly supportive of racial preferences in admission to medical school. The most active proponent is the Association of American Medical Colleges; the American Medical Association, the federal Council on Graduate Medical Education, and health philanthropies like the Robert Wood Johnson Foundation advocate racial preferences as well. Their goal is not necessarily to promote diversity for its own sake but to improve the health of minority patients. Support for affirmative action programs has indeed become a test of medical schools' commitment to minority health. "This is not a quota born out of a sense of equity or distribution of justice, but a principle that the best health care may need to be delivered by those that fully understand a cultural tradition," said George Mitchell, the former Senate majority leader and the chairman of the Pew Health Professions Commission.[1]

It is now claimed that a mismatch in race between doctor and patient—especially when the doctor is white and the patient is not—may be enough to trigger subtle, or not so subtle, biases that result in second-rate medical treatment and poorer health. In 1999 the U.S. Civil Rights Commission

informed Congress that "racism continues to infect" the health care system.[2] No less an authoritative voice than the American Medical Association's official newspaper has claimed that "a growing body of research reports that racial discrepancy in health status can be explained, at least in part, by racism and discrimination in the health care system itself."[3] This is why, according to the Reverend Al Sharpton, health will become the "new civil rights battlefront," a prediction echoed by other black leaders, including the Reverend Jesse Jackson and NAACP Chairman Julian Bond.[4]

President Clinton himself has spoken of race and health. "Nowhere are the divisions of race and ethnicity more sharply drawn than in the health of our own people," he said in a 1998 radio address delivered during Black History Month. It is indeed true that black Americans have higher infant mortality rates, more death from cancer, and lower life expectancies than whites and Asians. But it is far less certain that one of the possible explanations put forth by the president—"discrimination in the delivery of health care services"—is accurate.[5]

Given the history of systematic racial discrimination and segregation in the health care system, residual bias seems, at first, plausible. Indeed, medicine, like other institutions, once practiced overt discrimination. Black patients were treated on separate and inferior hospital wards—a policy that persisted among many hospitals in the Deep South until 1968. Black physicians were once routinely barred from joining hospital staffs and medical societies and started their own institutions to treat other blacks who were denied adequate care by the white-controlled medical facilities.[6] A particularly frightening episode in medical research was the unethical Tuskegee Syphilis Study.

Decades later, however, accusations of medical bias still linger. According to Vanessa Northington Gamble, a physician and director of the Division of Community and Minority Programs at the Association of American Medical Colleges, "Tuskegee symbolizes for many African-Americans the racism that pervades American institutions, including the medical profession."[7]

But the known facts suggest other interpretations of race-related dif-

ferences (or "health disparities"), and I shall present some of them here. This is not to minimize the facts of real discrepancies in access to care, certain medical procedures (even *with* insurance coverage), and in disease rates by race.[8] But I intend to show that they cannot be convincingly traced to bias against minority patients. My second aim is to look critically at one program intended to help close the health gap: racial preferences in medical school admissions.

Do Physicians Treat Minority Patients Differently?

A study in the *New England Journal of Medicine* in 1999 described differences in treatment of lung cancer between black and white patients who were beneficiaries of Medicare insurance.[9] In a careful analysis, Peter B. Bach and his colleagues at Memorial Sloan-Kettering Cancer Center in New York City looked at records of more than 10,000 patients who received diagnoses of operable lung cancer. Seventy-seven percent of the white patients underwent surgery compared with 64 percent of the blacks. Five years after diagnosis, only one-quarter of black patients were still alive compred with one-third of whites.

What accounted for the different rates of surgery? Did doctors not suggest the treatment as often to their black patients, or did these patients more often choose to forgo the recommendation for surgery? Were the black patients more likely to have poor lung function, such as more carbon dioxide buildup, or other problems that would have prohibited surgery or contributed to earlier demise? Details like these would go a long way toward explaining why surgery was never offered and why death rates differed, but those were not the questions that Bach and his colleagues set out to answer.[10] Indeed, the authors specifically said they could not offer an explanation based on the kinds of data they collected.

Other physicians, however, were ready with hypotheses. "Possibly, physicians are treating cancer patients not just based upon their illness and recommended treatment, but on the basis of their race," suggested

Dr. Hugh Stallworth of the American Cancer Society.[11] Dr. Harold Freeman, a surgeon and president of North General Hospital in Harlem, wondered whether white doctors might have been more scrupulous in getting white patients to accept surgery. "If you [as a doctor] were dealing with somebody who looked exactly like you, would you take another step?" he asked.[12] A more emphatic reaction greeted a report in the *Annals of Emergency Medicine* that found that 74 percent of white patients with fractures received pain medication compared with 57 percent of black patients.[13] "I think it's racism, flat out," said Dr. Lewis Goldfrank, director of emergency services at Bellevue Hospital in New York City.[14]

Responses like these would not surprise John Landsverk of Children's Hospital in San Diego. As he observed: "The usual implication of such disparities [in treatment rates] is that the health care system is biased against persons of the ethnic minority group and that the bias is likely to be found even in professional clinicians' perceptions of clinical problems and [referrals for] clinical procedures."[15] In light of this, Landsverk was especially enthusiastic about a study by a group of doctors at the University of Pittsburgh that found no race-related differences in treatment of children with behavioral problems.[16] Their report appeared in the journal *Medical Care* one month after Bach's study, but it attracted no public attention. It should have; it was "an important non-finding," as Landsverk noted in an accompanying editorial in the same journal. Not only did the Pittsburgh study include a very large sample—almost 15,000 children treated in clinics across the country and Canada—but also, most important, the researchers interviewed the parent and doctor of *every* patient. The results: race and ethnicity of the child had no relationship to clinician patterns in drug prescribing, referral, or diagnosis of behavioral problems. The clinicians also spent slightly *more* time with minority children than with their white counterparts.

This handful of studies is emblematic of the challenges inherent in interpreting health disparities research. First, the vast majority of treatment disparity studies are what scientists call "retrospective." That is, the raw data already exist in hospital records, and researchers use them (in retro-

spect) when they want to explore a specific question (e.g., are there more visits to emergency rooms on nights with a full moon?). The disadvantage of this approach is that key questions cannot be asked directly of the very people being studied: for example, did subjects in the study want or refuse a specific treatment? Did physicians offer it, and if not, why? Second, as Landsverk's reaction to the University of Pittsburgh study suggests, the *absence* of alleged racial bias does not make news. Consider the following example of a study that made a media splash the first time around.

A Misdiagnosed Case of Physician Bias

We know that black persons generally undergo cardiac catheterization less frequently than whites. Catheterization is a procedure used to discern whether there is blockage in the coronary arteries, the vessels that feed blood to the heart itself, and therefore whether the patient is at risk for a heart attack. The delicate process involves introducing a catheter into an artery in the leg and threading it upward toward the heart. When it reaches the point were the coronary arteries branch off, dye is squirted and the arterial patterns show up on a real-time X-ray. This is generally the first step in determining whether the vessels can be opened wider via a tiny balloon or whether some or all of the vessels must be replaced in a bypass operation.

Struck by the observation that black patients undergo catheterization less often than whites, Dr. Kevin A. Schulman and others at Georgetown University Medical Center wanted to examine how doctors made their decisions to refer patients for the procedure.[17] The researchers recruited 720 general internists at medical conventions and asked them to participate in a study of clinical decision making. The internists were not told that a primary purpose of the study was to explore how the race and sex of the patient might affect those decisions, nor were they told that the researchers expected to find that African Americans (and women) would be referred for cardiac catheterization less frequently than white men.

The doctors watched videotapes of actors wearing dressing gowns and

answering questions posed to them by an interviewer who elicited their complaints about chest pain and other relevant medical and personal history, including their insurance status. All the questions asked of the actors and their responses, down to the gestures used to describe the symptoms, were scripted to minimize inconsistencies. Overall, the doctors, who were mostly white, viewed 144 different videotapes, one for every possible combination of race, sex, and age and including differing clinical variables like the nature of the chest pain and the patient's stress test and EKG results.

The physicians were asked whether the patients' complaints appeared to reflect heart disease or another kind of distress, such as indigestion, and to rate the likelihood that the pain was indeed heart-related. As it turned out, all eight groups received similar ratings, leading the authors to assume the doctors would also refer for catheterization at similar rates. Yet, according to Schulman, "women and blacks were significantly less likely to be referred for catheterization than white men." About 9 percent of the white men were not referred versus 15 percent of the women and black patients. If representative of actual clinical outcomes, Schulman said, this would mean that blacks and women "were 40 percent less likely to be referred." Schulman misspoke, however: what it really would have meant was that white men had a 40 percent lower chance of *not* being referred. Quite a difference.

These findings were presented in an article titled, "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization," published in the *New England Journal of Medicine* in the winter of 1999. In the article Schulman and his associates speculated:

> Our findings that the race and sex of the patient influence the recommendations of physicians independently of other factors may suggest bias on the part of the physicians. However, our study could not assess the form of bias. Bias may represent overt prejudice on the part of physicians, or, more likely, could be the result of subconscious perceptions rather than deliberate actions or thoughts. Subconscious bias occurs when a patient's membership in a target group automatically activates a cultural stereotype in the physician's memory regardless of the level of prejudice the physician has.[18]

The study was a media sensation. On ABC's *World News This Morning*, Juju Chang told viewers: "How your doctor treats your heart may depend on the color of your skin. . . . The bias shows up in the diagnosis and doctors don't even realize it."[19] Peter Jennings predicted that the study would make "political waves" because it showed that "prejudice among doctors causes a gap in the quality of health care between blacks and whites."[20] On *Nightline*, Ted Koppel set up the story like this: "Last night we told you how the town of Jasper, Texas, is coming to terms" with the racially motivated murder of a black man; "Tonight we will focus on [doctors] who would be shocked to learn that what they do routinely fits quite easily into the category of racist behavior."[21] Newspaper headlines echoed the theme: "Cardiac Testing: Study Finds Women, Blacks Are Being Shortchanged," the *Chicago Tribune* said.[22] "Health Care: It's Better If You're White," announced the *Economist*.[23] The articles repeated Schulman's statement that black patients were 40 percent less likely to be referred.

Some of the most intense—indeed, self-flagellating—reactions came from the medical profession itself. An editorial in *The Lancet*, Britain's foremost medical journal, saw the findings as being "as close to a definition of institutionalized racism as doctors and health care providers may dare to get."[24] Aubrey Lewis, a Long Island cardiologist, warned on *Nightline* that "if this [physician bias] continues on, you're looking at literally a decimation of the African-American population."[25]

A Second Sober Look at Schulman's Study

A revelation came six months after the Schulman study appeared when the *New England Journal of Medicine*, the same journal that had printed Schulman's study, published a powerful rebuttal. This analysis was by Lisa M. Schwartz, Steven Woloshin, and M. Gilbert Welch, all physicians at the White River Junction Veterans Administration Hospital in Vermont, who reanalyzed Schulman's data to show that the average referral rates for three of the four groups were in fact the same.[26] White

men, white women, and black men were all referred at the rate of 9 in 10; only black women, for unclear reasons, had a lower referral rate, about 8 in 10. Put another way, black women were 87 percent as likely as white women and men of both races to be referred for catheterization. And black men were treated just as aggressively as both white men and white women.

The doctors from White River Junction also expressed dismay at what might be called the statistical sleight-of-hand that supported the Schulman hypothesis of physician referral bias. "The probability of referral for blacks was 7 percent lower. . . . These exaggerations serve only to fuel anger and undermine the trust between physicians and their patients," the White River Junction doctors wrote. They were not alone in expressing concern; the *NEJM* editors published a note in the very same issue regretting that they had not required the authors to use more straightforward statistical measures. "We take responsibility for the media's over-interpretation of [this] article," they admitted.[27]

Even after seeing how his findings had been interpreted by the press and used to goad racial resentments, Schulman would not budge. "Our study will . . . encourage the medical profession to seek ways to eliminate unconscious bias that may influence physicians' clinical decisions," he maintained.[28] Also sticking with Schulman' s interpretation was Paul Douglass, a cardiologist at Morehouse School of Medicine. "You can argue with statistics all day," he told *USA Today;* "we have to face the reality of our situation: There is a gender and racial bias."[29] Compared with the tidal wave of coverage triggered by the Schulman study, the article by Schwartz and her colleagues generated a mere trickle of media interest, as noted by columnist John Leo and the media magazine *Brill's Content.*[30]

Alternative Explanations for Differences in Treatment

Accusations of bias make headlines. Less catchy are the mundane but meaningful explanations that are more faithful to the clinical situations that doctors and patients face every day. A judicious approach

to the topic has been adopted by the Kaiser Family Foundation. "Even when differences persist, it should be noted that every differential in care is not necessarily a problem," says a 1999 foundation report, "and that the level of care obtained by whites may not be the appropriate standard for comparison."[31]

One reason, for example, that procedure rates differ is that medical problems do not necessarily occur with the same frequency across races. Consider: Uterine fibroid tumors, and thus hysterectomies, are more common in black women than in whites, while osteoporosis-related fractures, and thus hip replacement, are rarer. Limb amputation is more common among black patients because thicker atherosclerosis of the blood vessels in the leg makes it harder to perform limb-saving surgery.[32] African Americans suffer stroke at many times the rate of whites, yet undergo a procedure to unclog arteries in the neck (endarterectomy) only one-fourth as often. Racism? Unlikely. It turns out that whites tend to have their obstructions in the large, superficial carotid arteries of the neck region that are readily accessible to surgery. Blacks tend to have their blockages in the branches of the carotids. These smaller branches run deeper and farther up into the head where the surgeon cannot reach them.[33]

Another consideration is the clinical condition of the patient. Does he have other medical problems that alter the risk-to-benefit ratio of a procedure, making it less favorable? The treatment of heart disease, for example, often needs to be modified in the presence of uncontrolled high blood pressure and diabetes—conditions more typical of black patients with heart disease than of white patients.[34]

Then there is the site of care itself. Some hospitals, for example, simply do not offer certain cardiac procedures. Dr. Lucian L. Leape and his colleagues at the Harvard Medical School found that about one-quarter of all patients needing cardiac procedures failed to get them, in large part because they were admitted to hospitals that did not offer them. Notably, Leape found that failure to undergo procedure occurred at equal rates across all groups of patients—black, white, and Hispanic.[35]

Conversely, under systems of available medical care in the United States

(e.g., veterans' affairs medical centers, the military services), some differences in treatment melt away. For example, patients with colorectal and prostate cancer treated in those systems showed no race-related differences in treatment availability, treatment methods, or survival rates. Yet in other instances, even with good health insurance coverage, African American patients may have a lower chance of receiving certain procedures.[36] If money is not an issue in those instances, then the difference in treatment *must* represent bias on the part of the doctors, say those who are quick to charge bias when outcomes differ by race.

As we've seen, this charge makes very lively headlines. But a different interpretation is plausible: that the patients' clinical needs rather than the doctors' personal biases are dictating the care. After all, if not for concern about the patient, why wouldn't physicians perform a reimburseable procedure?

The factors discussed so far are only some of the determinants of whether patients undergo procedures. We must also consider patients' attitudes toward care. For example, what is the nature of a person's belief in his susceptibility to disease, the seriousness with which he perceives disease, and his confidence that treatment will work?[37] Social scientists call this the health belief model. Culturally influenced ideas about illness also play a role in patients' decisions to refuse or delay screening tests and interventions. Fatalistic attitudes toward the value of preventive care and the outcomes of disease as well as magical thinking (e.g., that the devil can cause cancer, that mammography machines cause breast cancer) and the use of folk remedies are more prevalent in minority groups.[38]

Says Lorna G. Canlas, a nurse with an East Harlem clinic that cares for a Latino population, "Most clients I encounter need to be persuaded of the validity and utility of modern medical practices.[39] Other studies have documented a greater aversion to surgery among African American patients compared with whites, even when the white patients' perceptions of current health state, level of education, and age were all taken into account.[40]

A Hasty Allegation of Bias

Kidney transplantation has come under scrutiny of the U.S. Commission on Civil Rights in its 1999 report as a case of "health care inequity," in part because African American patients spend considerably more time on the waiting list for a new kidney than do white patients.[41] This means that they spend more time on the dialysis machine—a thrice-weekly, hours-long process that cleans the blood of toxic products. The ideal treatment is kidney transplantation, but the process is a complicated one. Before a patient can receive a kidney, there must be attempts to "match" the donor with the recipient so that the recipient's immune system does not attack, or "reject," the new kidney. The better the match of biological variables, the better the outcome. According to a report issued by the UNOS Histocompatibility Committee, black recipients wait longer owing to factors such as blood type, sensitization, and some antigens (immune proteins made by the cells).[42]

A technique called antigen matching is used to test for different combinations of six major antigens found on tissues. A perfect six-out-of-six match is the ideal condition for compatibility between donor and recipient. Unfortunately, a complete match is far less common in African American transplant candidates than in whites because they have more possible antigen combinations than whites and some of those antigens are very rare in the general population.

Scientists are still debating the precise physiology of organ rejection and the importance of near-perfect antigen matching. What they do know is that black transplant recipients are more likely to reject their new kidneys. Possible reasons include poor control of hypertension or a more vigorous immune response.[43] Even well-matched transplants can be lost to rejection, suggesting that the standard antigen-matching system may be too simplistic.[44] Clearly, we need a better understanding of transplant immunology so that we can develop new and better medications to prevent rejection.[45]

Meanwhile, if the compatibility is marginal, it is sometimes most prac-

tical for the physician to have the patient stay on dialysis longer to wait for a better match. Losing scarce organs to rejection from mismatch actually makes the recipient more likely to reject future kidneys. Also, every rejected kidney means one less donor kidney available to the other people on the waiting list. This is a critical point because donor kidneys are among the nation's scarcest resources. In 1996, for example, more than 70,000 Americans began dialysis for severe renal disease, but only 12,000 received transplants.[46]

Most patients on dialysis, especially black persons, get their organs from donors that are deceased, so called cadaveric donors. Once on the waiting list, how do black patients fare in the allocation of kidneys from cadavers? In 1997 black patients represented one-third of the waiting list for cadaveric kidneys and, as a group, donated 11 percent of all cadaveric kidneys and received 27 percent of them. Thus, more than half of all kidneys received by black transplant recipients came from donors of other races (predominately white). Donation is a gift of life that transcends racial scorekeeping—but it is important to look closely at the numbers when bias in allocation of kidneys is alleged.

Rationale for Affirmative Action in Medical School

Whether the quality of health care for minority patients truly depends upon producing greater numbers of minority physicians is an unresolved empirical question. Nonetheless, proponents of racial preferences in medical school admissions contend that white physicians treat white patients better than minority patients, with whom, it is said, they have difficulty developing a rapport.[47] To be sure, understanding a patient's cultural tradition is important, but need one actually be a product of that tradition to be sufficiently sensitive to a patient? Virtually all the major medical organizations say yes.

Foremost among them is the Association of American Medical Colleges (AAMC).[48] When California and Texas were planning to dismantle racial

preferences in 1996, the AAMC formed Health Professionals for Diversity, a coalition of major medical, health, and educational associations, to lobby for the preservation of preferences. By the time Initiative 200, the Washington State referendum to prohibit preferences by race, ethnicity, or gender in public institutions, was on the ballot in 1998, the coalition included fifty-one associations among its membership. According to an association vice president, the true message of race-neutral policy to minority students was: "We don't want you."[49]

Given the relatively small numbers of black, Hispanic, and Native American physicians (3 percent, 5 percent, and less than 1 percent of the nation's medical workforce, respectively), compounded by the declining number of minority applicants in the late 1990s, many feel that medical schools need to rely on racial preferences if they are to boost these numbers in the next few years.[50] (Asian Americans are not considered a minority because they are well represented among practicing physicians: 10 percent versus 4 percent of the general population.)

Racial preferences played a role in raising first-year enrollment to the point where, by 1999, it had reached 8 percent black and about 7 percent Hispanic, though it remains 1 percent Native American.[51] But recruitment has been difficult. In 1995, when racial preferences in medical schools were nearly universal, only about 12 percent of first-year students were black, Hispanic, or Native American. The recruitment challenge was characterized by Robert G. Petersdorf, former president of the AAMC, as follows: "We cannot produce underrepresented minority medical students if there is an insufficient number who are applying to our schools, graduating from college, or even finishing high school with sufficient skills to enable them to survive a premedical course of study."[52] Nonetheless, by 2010 the AAMC hopes to attain racial and ethnic representation among physicians that is in proportion to the general population.

The impact of race-neutral policies in some states will make the 2010 parity goal even more elusive. Within two years after Proposition 209 passed in 1996, there was a 29 percent drop in applications by minorities to six public medical schools in California.[53] This set alarm bells ringing through-

out the medical establishment. "There is a national health need for physicians who, after the Tuskegee Syphilis Study, for example, are trusted by large segments of our population," wrote Michael J. Scotti Jr. of the American Medical Association. "It would be deplorable," he went on, "if medical schools were not permitted to consider the needs of patients when determining their criteria for selecting the best qualified applicants."[54] H. Jack Geiger, a professor of public health at the City University of New York, in an essay in the *American Journal of Public Health*, "Ethnic Cleansing in the Groves of Academe," foresaw these "reversals in minority admissions [as] merely the leading edge of a potential public health disaster."[55] A public health disaster? Only if there is nothing more important to Americans about their doctors than race.

Caring Trumps Color

Only a handful of studies have been devoted to the question of whether patients' outcomes are better if they and their doctors are of the same race. Many of these studies were conducted with psychiatric patients, and the majority show that the clinician's race has very little to do with how black and white patients fare in their treatment and recovery.[56]

According to a 1994 Harris poll for the Commonwealth Fund called Health Care Services and Minority Groups, race does not play an especially large role in patients' attitudes about their doctors. When asked to cite the "things that influence your choice of doctor," the physician's "nationality/race/ethnicity" ranked twelfth out of thirteen possible options; just 5 percent of whites and 12 percent of minorities said it was important. A greater portion of Asians, 28 percent, rated race/ethnicity as important, probably because of language barriers. Even so, over 60 percent of white, black, and Hispanic respondents said they did not consider the doctor's ability to speak their language particularly relevant to their choice of doctor.[57]

For the entire group of 4,000 respondents, factors such as ease of getting an appointment, the convenience of office location, and the doctor's reputation were most influential, cited by about two-thirds of respondents. When respondents who expressed dissatisfaction with their regular doctors

were asked for details, only Asians claimed that race or ethnicity was the problem (and the percentage was small, only 8 percent of all Asian respondents). Among the subset of the entire sample who said they "did not feel welcome" at their doctors' offices, a mere 2 percent of African Americans and Hispanics attributed the discomfort to racial/ethnic differences.[58]

The main complaint of almost all groups was "failure to spend enough time with me." And of those who were so dissatisfied that they changed doctors, only 3 percent of Asians and 2 percent of blacks did so on the basis of the physician's race or ethnicity. The most common complaints were "lack of communication," "didn't like him or her," "couldn't diagnose problem," or "didn't trust his or her judgment." Less than one percent of people polled said that they felt limited in their options for care because of racial or ethnic discrimination.

Thus, in this era of managed care's fifteen-minute doctor visit, what much of the research on attitude really tells us is that most patients attach more value to the amount of time they can spend with their doctors than they do to the doctor's race or ethnicity. When patients see a different doctor each time they go to the clinic, as is often the case with municipal clinic patients and those whose HMOs have high turnover, it is even harder to establish comfort and trust.

Academic Performance and Racial Preferences

Acceptance rates for minority students to medical schools have long been higher than rates for white and Asian applicants with similar qualifications, according to the Association of American Medical Colleges. In 1979, for example, a minority student with high grades and board scores had a 90 percent chance of being admitted to medical school, while a white applicant with comparable qualifications had a 62 percent chance. By 1991, the last year for which AAMC has published data, the figures were 90 percent versus 75 percent. And a low-scoring minority applicant had a 30 percent chance of admission, while a similarly low scoring white applicant had a 10 percent chance.

At the University of South Florida College of Medicine, for example, between 1995 and 1997, black applicants with a B+ grade-point average had a roughly 13 percent chance of admission, whereas white and Hispanic applicants with the same grade-point average had only a 4 to 5 percent chance.[59] Even with the passage of Proposition 209 in 1996 in California, minority applicants to some of California's public medical schools were two to almost three times as likely to be admitted as whites and Asians with considerably higher grades.[60]

Notwithstanding the clear race-based advantages in admission to medical schools, the U.S. Commission on Civil Rights charged discrimination, noting a "persistent yet baffling denial of the social, economic, and historical realities depriving our profession of minority physicians."[61] True, many minority students have suffered unfairly in second-rate primary and secondary schools, but medical school seems a risky point in the academic pipeline at which to give an academic break.

Sadly, black and Hispanic applicants, who are favored in medical school admissions, also are overrepresented among students who encounter trouble in medical school. According to the AAMC, they are more likely than other students to repeat their first year or to drop out.[62] Of the medical school class admitted in 1989, over 20 percent of minority students did not graduate four years later, as is typical, with the class of 1993; of white and Asian students in the same class, only 8 percent failed to graduate.[63] In 1996 the picture worsened across the board: 39 percent of minority students were unable to keep pace compared with 15 percent of nonminority students.[64] A 1994 study published in the *Journal of the American Medical Association* found that in 1988 51 percent of black medical students failed Part 1 of the National Medical Boards (taken after the second year of medical school), more than four times the 12 percent rate of white students. (Failure rates for Hispanic students were 34 percent, and for Asians, 16 percent.)[65]

The typical path for students after graduating from medical school is application to residency programs in a chosen specialty. At this level, too, there are different outcomes. "It has been documented consistently over the past decade that a higher proportion of underrepresented minority

students failed to obtain first-year residency positions through [the standard process]," wrote Gang Xu of Jefferson Medical College in Philadelphia and colleagues.[66] Moreover, for the period 1996–1999, the yearly dismissal rate for black residents in residency programs (14.4 percent) was almost double that for other groups (7.7 percent).[67] Reasons for dismissal can include persistently unprofessional behavior, chronic absenteeism, and lack of aptitude or interest.

These problems encountered by black and Hispanic medical students are the result of admitting students who are underqualified. When black students were compared with whites who had similar academic credentials, the failure rates were similarly low.[68] A 1987 study by the RAND Corporation found that only about half of black physicians obtained board certification compared with 80 percent of white physicians. Yet African Americans were *more* likely than white physicians to obtain "board certification" in a recognized medical specialty if their grades in college and on the Medical College Admissions Test were strong enough to get them admitted on a competitive basis in the first place.[69]

Though the subject deserves more research, a handful of studies have linked medical school performance with the quality of the physician produced. Robyn Tamblyn of McGill University and colleagues found that licensing examination scores were significant predictors of whether Canadian physicians sought consultations from specialists, prescribed appropriately, and ordered screening mammograms for female patients aged 50–69. Given Canada's universal health insurance, these referral and medicating patterns were unlikely to have been influenced by patients' ability to pay.[70] Another study, among American doctors, found that passing grades on the test to become a specialist (e.g., a cardiac surgeon, a neurologist) and the scores received on the internal medical licensing exam correlated with ratings of performance in practice by fellow doctors.[71]

An Honest Debate

Instituting racial preferences toward the goal of diversity for its own sake or in the spirit of compensation for historical mistreatment

are philosophical abstractions for debate in courtrooms, classrooms, and legislatures. But instituting preferences in order to enhance minority health is a practical proposition that can actually be tested using real-world data. Thus far, in my view, the case has yet to be made that improving minority health depends on having more minority doctors.

Racial preferences would seem, for several resons, to be an inefficient way to increase the number of minority doctors—and, thus, minority health. First, simply put, minority representation over the last decade has been fairly stagnant in spite of aggressive admissions policies. Second, minority recruitment has resulted in a two-tiered system of academic standards for admission that has created attendant problems of fairness to other potential medical students and of propelling some students into a career for which they are ill prepared. Third, we lack compelling evidence that same-race (minority) doctor-patient relationships result in better patient outcomes.

No matter who treats our nation's poor and minority patients, we must recognize that they tend to have multiple, chronic medical conditions and are often clinically complicated. They need the best doctors they can get, regardless of race. Not enough doctors choose to work in rural community clinics and poor, inner-city neighborhoods; moreover, in a number of states such as Florida, Illinois, North Dakota, Texas, and New York graduates of foreign medical schools represent one-fourth to one-half of the physician workforce in underserved areas.[72] California has approved legislation requiring its public medical schools to increase the number of training slots for primary-care physicians and to decrease slots for specialists.[73] Other approaches use creative financial incentives (e.g., loan forgiveness, rent rebates, higher pay) to draw young doctors into rural and inner-city communities. We should be capitalizing on these strategies, not lowering standards for admission to medical school.[74] As far as patient preferences are concerned, again it would make more sense to create mechanisms that ensure patient choice than to open the doors of medical schools to unprepared students.

Finally, we must not forget that the physician is part of a larger network

of health care providers. For some preventive care (e.g., vaccinations for children and the elderly, prenatal care, routine infant checkups, and blood pressure surveillance), physicians are not even needed. Specially trained nurses can help provide after-hours medical appointments and give basic advice over the telephone; public health nurses or physician assistants cooperating with local churches and community organizations can deliver these services at least as effectively. Inner-city hospitals are now hiring health educators (ideally from within the community) to teach fellow residents about diet and exercise, smoking cessation, and screening for cancer, diabetes, and hypertension. These workers also participate in outreach efforts to get people into clinics for routine care—an important task because medically indigent people tend to underuse available care, show up in emergency rooms for minor problems, and receive diagnoses for conditions like cancer at an advanced stage.

While well-meaning groups like the AAMC advance the questionable belief that minority health is dependent on minority physicians, evidence points more vigorously toward the virtues of promoting health literacy, the formation of community–health organization partnerships, and the expansion of health coverage to the uninsured. What patients most seem to want is a qualified doctor who will spend unhurried time with them. The racial disparities in health are real, but data do not point convincingly to systematic racial bias as a determinant—nor to the need for racial preferences in medical school admissions as a remedy for health disparities.

Notes

1. Quoted in Laura Meckler, "Panel: Diversify Medical Workforce," Associated Press, December 9, 1998.

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