

## Making a Difference in Disparities

Paul S. Chan, MD, MSc; John A. Spertus, MD, MPH; Brahmajee K. Nallamothu, MD, MPH

Much of cardiovascular outcomes research—including the work published in this journal—addresses health-care disparities.<sup>1-3</sup> As researchers, we frequently describe disparities and, rarely, even suggest and test strategies to reduce them. But, beyond scientific publications, what is the role of the physician and researcher as social advocate and citizen to reduce disparities? That important topic is one we rarely address. Yet it has been increasingly on our minds as Editors given the growing and complex challenges we now see to the health of our patients, which range from accessing affordable care to healthy home environments to climate change.

We think there is a critical obligation for the cardiovascular outcomes research community to respond to these challenges—perhaps even more so than for other citizen groups. We think that we cannot simultaneously posit concerns about population health and outcomes if we are not integrally involved in making individual lives whole. If we do, we risk the danger of creating a one-sided relationship with our most vulnerable patients—they share with us their deepest concerns and pains while we offer little in reciprocation. For many of our studies, we are allowed unique insights into their fears and vulnerabilities, predicated on a trust that we will work to advance their health to the fullest extent we can. Furthermore, lots of studies in disparities are done at a distance and on administrative databases that do not really connect at all with the lives of these individuals.

Do not mistake our intentions. We love our work as physicians and researchers. We think that trying to tackle disparities is incredibly meaningful work and applaud our community for tackling these challenges. Yet despite the great rewards this provides us from a professional standpoint, we think that many of us do, or should, want more. Many of us entered into healthcare with a parallel ideal for health rooted in social justice. This paradigm differs from the concept of justice in bioethics—which posits that the benefits, risks, and costs of treatments must be distributed equally among all groups in society. Instead, it asserts that, as physicians and researchers,

we are in a unique position to advocate on behalf of populations to make it easier for them to avoid disease and promote health, especially for our most vulnerable patients.

We see 2 major challenges to promoting health rooted in social justice. The first is philosophical. Some argue that there are important limits for concepts, such as social justice in the profession of medicine.<sup>4</sup> They posit that although the pursuit of social justice may be a worthy goal for all citizens, the responsibility should not be restricted to a few groups, such as physicians and researchers. We agree that ideally advocacy and service should not be part of medicine's professional norms but rather of societal norms. As a profession, however, it turns out that we may not even be doing our fair share. Limited data suggest only a minority of physicians volunteer in any given year, and physicians may be half as likely to volunteer as the general public or other professions (eg, lawyers).<sup>5</sup>

The second challenge is more practical: how do we do it? It could be that our medical education and research careers have left us woefully unprepared to be advocates in society, even as it has left us well versed in the anatomy, pathophysiology, and treatment of illness. This makes it all too easy to stick to the medical side of doctoring when rounding in the hospital or seeing patients in clinic. Or to focus on the technical aspects of study design rather than what these results might mean to a specific person or family. It is easy to assume that it is others' responsibility to figure out the nonmedical challenges.

Although we expect our patients or subjects to listen to us, we often fail to listen to them or be aware of their circumstances. For example, we may label patients as noncompliant when, in fact, (1) healthcare is their fourth priority after food, housing, and heat; (2) they cannot exercise in their neighborhood because it is experiencing record gun violence and homicides; and (3) they cannot take an afternoon off for their 1-week follow-up appointment because their minimum wage employer might fire them. By not being cognizant of an individual's social, economic, and emotional lives, our efforts to improve healthcare are largely restricted to more affluent populations without these concerns.

So how can we think about our work more broadly in the context of social advocate and citizen? We do not pretend to know the answers, and it is unlikely that it will be the same answer for each of us. But we do have 3 suggestions that we think can make an impact:

- Engage more: Personally, we have resolved to be better listeners with our patients and subjects. At least once a week, one of us (P.C.) has incorporated a weekly meal with some of the most vulnerable in Kansas City. On any given night, at least a third of the volunteers are the homeless themselves. These meals can remind one of why many of us went into medicine in the first place and

---

The opinions expressed in this article are not necessarily those of the American Heart Association.

From Saint Luke's Mid America Heart Institute, Kansas City, MO (P.S.C., J.A.S.); the University of Missouri-Kansas City (P.S.C., J.A.S.); the Department of Internal Medicine, Michigan Integrated Center for Health Analytics and Medical Prediction, University of Michigan, Ann Arbor (B.K.N.); and the Center for Clinical Management and Research, Ann Arbor VA Medical Center, MI (B.K.N.).

Correspondence to Paul S. Chan, MD, MSc, Saint Luke's Mid America Heart Institute, 4401 Wornall Rd, Kansas City, MO, 64111. E-mail: paulchan.mahi@gmail.com

(*Circ Cardiovasc Qual Outcomes*. 2017;10:e004287.

DOI: 10.1161/CIRCOUTCOMES.117.004287.)

© 2017 American Heart Association, Inc.

*Circ Cardiovasc Qual Outcomes* is available at <http://circoutcomes.ahajournals.org>

DOI: 10.1161/CIRCOUTCOMES.117.004287

provide a far richer context with which to understand the struggles of our patients.

- Move from description to action: As a member of the cardiovascular outcomes research community, we need to conduct disparities research differently. We need to shift from writing articles that describe inequalities to offering and testing solutions. We need to move from the hospital and clinic to the community. Describing disparities in healthcare settings is necessary but not sufficient to tackling many of our patients' most urgent problems. As Editors at *Circulation: Cardiovascular Quality and Outcomes*, we will try our best to share the work of investigators testing new strategies to improve health and reduce disparities in our journal.
- Get involved: As physicians and researchers, we think each of us is also called to be healers in our local and global communities. This has less to do with a particular political perspective and more to do with the understanding that our most important scientific contributions do not end with the publication of an article. In this era of fake news, we need to better recognize the implications of our work more broadly and share these ideas with others. This could mean a well-timed opinion piece in the local paper, working with a nonprofit you deeply think in, or volunteering in the community.

As we enter autumn, we are reminded of the greatest lesson the seasons provide us: life never stands still. During this time

that has traditionally represented the abundance of harvest, most of us will celebrate our blessings with family and friends punctuated by the traditional Thanksgiving and Christmas holidays. We think this is a ripe opportunity for those of us interested in health disparities to also change our habits and to think of ways to become more invested in the social and economic lives of our vulnerable patients. Let us begin.

## Disclosures

None.

## References

1. Li S, Fonarow GC, Mukamal KJ, Liang L, Schulte PJ, Smith EE, DeVore A, Hernandez AF, Peterson ED, Bhatt DL. Sex and race/ethnicity-related disparities in care and outcomes after hospitalization for coronary artery disease among older adults. *Circ Cardiovasc Qual Outcomes*. 2016;9(2 suppl 1):S36–S44.
2. Evans JD, Kaptoge S, Caleyachetty R, Di Angelantonio E, Lewis C, Parameshwar KJ, Pettit SJ. Socioeconomic deprivation and survival after heart transplantation in England: an analysis of the United Kingdom Transplant Registry. *Circ Cardiovasc Qual Outcomes*. 2016;9:695–703. doi: 10.1161/CIRCOUTCOMES.116.002652.
3. Aarnio E, Martikainen J, Winn AN, Huupponen R, Vahtera J, Korhonen MJ. Socioeconomic inequalities in statin adherence under universal coverage: does sex matter? *Circ Cardiovasc Qual Outcomes*. 2016;9:704–713. doi: 10.1161/CIRCOUTCOMES.116.002728.
4. Huddle TS. The limits of social justice as an aspect of medical professionalism. *J Med Philos*. 2013;38:369–387. doi: 10.1093/jmp/jht024.
5. Grande D, Armstrong K. Community volunteerism of US physicians. *J Gen Intern Med*. 2008;23:1987–1991. doi: 10.1007/s11606-008-0811-x.

## Making a Difference in Disparities

Paul S. Chan, John A. Spertus and Brahmajee K. Nallamothu

*Circ Cardiovasc Qual Outcomes.* 2017;10:

doi: 10.1161/CIRCOUTCOMES.117.004287

*Circulation: Cardiovascular Quality and Outcomes* is published by the American Heart Association, 7272  
Greenville Avenue, Dallas, TX 75231

Copyright © 2017 American Heart Association, Inc. All rights reserved.

Print ISSN: 1941-7705. Online ISSN: 1941-7713

The online version of this article, along with updated information and services, is located on the  
World Wide Web at:

<http://circoutcomes.ahajournals.org/content/10/10/e004287>

**Permissions:** Requests for permissions to reproduce figures, tables, or portions of articles originally published in *Circulation: Cardiovascular Quality and Outcomes* can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the [Permissions and Rights Question and Answer](#) document.

**Reprints:** Information about reprints can be found online at:  
<http://www.lww.com/reprints>

**Subscriptions:** Information about subscribing to *Circulation: Cardiovascular Quality and Outcomes* is online at:  
<http://circoutcomes.ahajournals.org//subscriptions/>