The Gap in Current Disparities Research
A Lesson From the Community

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Once again this year, along with ≥300 outcomes and health services researchers, I attended the American Heart Association’s Quality of Care and Outcomes Research conference during the first week of June in Baltimore. I started coming to this unique conference nearly a decade ago. With some of the world’s leading authorities on quality and appropriate-ness of care, healthcare disparities, and research methods, this conference has been a critical venue for my academic and personal development because its intimate size has facilitated the development of several mentorship relationships for me.

Starting in 2012, some of us have stayed on after the conclusion of the conference to do community service for an afternoon in the host city before returning to our home towns. We typically work in a food bank or serve a meal at a shelter, and this experience has been one of my favorite parts of the conference, as a core group of us have gotten to know one another better outside of the traditional academic environment. This year, we deliberately planned a more thought-provoking experience by spending time talking with the founders of the organizations we visited. A diverse group of 14 of us, ranging from an editor-in-chief of a Circulation journal, a Dean of Nursing, various academic faculty, and 3 trainees devoted 4 hours at 2 local community organizations. As a group, we had collectively published ≥1000 articles, with several of them focused on socioeconomic and racial disparities in care.

We began at the Bea Gaddy Center in East Baltimore, on the periphery of the Johns Hopkins Hospital. Bea Gaddy was an iconic figure in her day, rallying diverse resources to feed and clothe the hungry. Called the Mother Teresa of Baltimore by the local Baltimore Sun newspaper, her center still feeds a mind-numbing 50 000 people every thanksgiving. Our group spent time sorting their food pantry for expired food and putting together large food sacks, which the Center distributes daily to needy folks. Some of those who lined up on this day were homeless; others had homes but little money to buy their own food. During our visit, Cynthia (daughter of Bea) recounted the innumerable challenges faced by people living in poverty in East Baltimore today—insufficient Food Stamps subsidies (average of $133 monthly) resulting in hunger even among the working poor, inner city food deserts (with no supermarkets for miles), high rates of heroin and crack cocaine use, pervasive gun and gang violence, unimag-
Our cardiovascular outcomes community spends enormous (and important) amounts of time writing guidelines, measuring disparities, assessing adherence to evidence-based therapy, and identifying gaps and variations in care. As each of us processed our experiences that afternoon in Baltimore, several things were apparent to members of our group:

1. Health is one of many pressing priorities for poor people. It seems obvious to say this, but we as healthcare professionals often focus only on the medical condition of the patient and not the patient as a whole. It is really challenging for a patient with heart failure who is poor to adhere to their medication and fluid restriction treatment plan because they inevitably have to deal with competing economic challenges when they are discharged from the hospital. Decisions about whether they can pay for their medications are common, as even the small $4 copay for generic medications equals their daily Food Stamps allotment, let alone whether they have the means to buy fresh fruits and vegetables and avoid much cheaper but less healthy canned soups and foods. Poor patients with extremely meager financial resources are routinely labeled as noncompliant and frequent-flyers in our healthcare system, but the underlying reasons for their inability to adhere to our medical treatment plans may have more to do with their competing daily challenges of extreme poverty, hunger, health illiteracy, gang violence, and single parenthood.

2. The status quo of disparities research is untenable. The experiences at the Bea Gaddy Center and Viva House made us uncomfortable because they challenged the core of our research mission: at the end of the day, have any of our papers on racial and socioeconomic disparities (some of them even in high-impact journals) really improved our brothers’ and sisters’ lots in the healthcare world? During the past 3 to 4 decades, our research community has successfully described socioeconomic and racial gaps in healthcare outcomes, but it is less clear that we have succeeded in developing effective programs and interventions that have reduced these disparities. Despite our best intentions, we seem to have fallen into the proverbial ivory tower trap, with our articles advancing our careers but accomplishing little to change the health of the poor so that we can give voice to their concerns. If we want our efforts to promote health and prevent disease to succeed, we may need to walk in solidarity with those we write about and start educating ourselves and fight for programs, which would make it much easier for people to become healthy. There is, of course, no one-size-fits-all prescription of what we can or should be doing. However, by becoming engaged in our patients’ worlds in incremental but meaningful ways, we move away from medicalizing their conditions and gain a more complex and fuller appreciation of how their disease conditions are shaped by social and economic constructs.

We all felt uncomfortable during our experiences that afternoon in Baltimore because we felt powerless and helpless, after immersing ourselves, however briefly, in the real-world issues of poor folks in 1 inner city. As a talented group of researchers, we were not used to feeling that our volumes of disparities papers may have achieved little after all. However, if we are serious about disparities, we need to keep in mind that (1) health is one of many pressing priorities for poor people, (2) the current format on disparities research needs to shift to developing programs and interventions, which can make a difference, and (3) as a healthcare community, we need to find ways to make it easier for people to be healthy. We need to practice what Simone Weil, the 1930s French philosopher and mystic, called “intellectual honesty”, and redouble our efforts on disparities research so that the chasms separating white from black, poor from rich, uninsured from privately insured, can start to narrow. And if we have the humility to walk this walk, realizing that even if that gap does not close quickly in a year or 10 years, such a journey of earnestly walking in solidarity with the marginalized in our midst will break down the barrier of “us” talking about “them” as poor people and refocus the discussion about “we” as a human community.

Acknowledgments

I thank Drs Anderson, Nallamothu, and Spatz for their inspiration, encouragement, and constructive comments for this commentary.

Disclosures

None.

Key Words: healthcare disparities | outcome assessment (health care)
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Circ Cardiovasc Qual Outcomes. published online August 5, 2014;
Circulation: Cardiovascular Quality and Outcomes is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2014 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/early/2014/08/05/CIRCOUTCOMES.114.001234.citation

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