

BOOK REVIEWS

**UNEQUAL TREATMENT:
CONFRONTING RACIAL AND ETHNIC
DISPARITIES IN HEALTH CARE**

Edited by Brian D. Smedley, Adrienne Y. Stith,
and Alan R. Nelson. 764 pp. Washington, D.C.,
National Academies Press, 2003. \$79.95.
ISBN 0-309-08532-2.

THE LIFE EXPECTANCY OF MEMBERS OF most minority groups in the United States is shorter than it is for white Americans. For example, the gap in life expectancy between black Americans and white Americans is about six years. Against this bleak backdrop, a group of scholars assembled by the Institute of Medicine has taken on the issue of racial disparities in health care. In *Unequal Treatment*, they deal with several questions. In the United States, are there disparities in treatment between patients who are members of minority groups and those who are not, when both groups have similar access to care? If so, can we determine what underlies these disparities and what we should do about them?

The medical literature reviewed in this book should convince even skeptics that members of minority groups receive treatment for their health problems that is different from the treatment received by others. However, determining whether these differences exist when all patients have equal access to care is a thornier issue. Two approaches are commonly used to analyze this problem: one is to examine the treatment of patients at a single location; the other is to investigate the treatment of patients who have the same insurance. Unfortunately, both of these experimental designs fall short of the ideal condition, in which all patients have equal access to the same range of services and expertise. As a result, no one can be certain whether disparities in treatment reflect unequal treatment of two groups of patients with equal access to health care or unequal treatment of two groups owing to a difference in resources, such as the availability of subspecialists and well-stocked pharmacies.

After careful consideration of the evidence, the editors favor the former explanation: unequal treatment despite equal access. They ground this view in

well-described and engaging theories about the roles of race, nonverbal communication, and inferential thinking that invisibly alter the clinical encounter between a patient who is a member of a minority group and a physician who is not. They conclude that “stereotyping, biases, and uncertainty on the part of the healthcare providers can all contribute to unequal treatment.” This conclusion is important and remarkable, in that it redefines the problem of disparities in health care as a problem not of uneven access but of moral failure.

In this context, the editors’ recommendations make sense. Poor treatment of minorities should be considered an abrogation of civil rights. Doctors’ understanding of their minority patients should be enhanced through educational programs on disparities in treatment and on cultural competency. The medical profession’s myopia regarding minority issues should be addressed by enriching the physician workforce with more members of minority groups.

I believe, however, that if we focus our attention on eliminating racial disparities, we will fall short of our aspirations. Decades of research have shown that the care received by patients who do not belong to a minority group is also frequently of poor quality, meaning that by aiming for parity we aim too low. An alternative is to focus purely on maximizing the quality of care received by underserved populations. Our success in this endeavor would be reflected within these communities, rather than measured by comparison with other populations. We could provide additional reimbursement to physicians who treat underserved patients, rather than threaten them with charges of civil-rights violations. In England, the National Health Service has experimented successfully with a deprivation payment system. According to this system, general practitioners who work in underprivileged areas of the country receive additional reimbursement for the care they provide, in part on the premise that the barriers to providing optimal care are greater in such areas.

We could also target the specific conditions that most impair health and economic viability in minority communities. Currently, childhood asthma is rampant in inner cities and has severe economic consequences for affected families: every exacerbation

tion requires both the child and the caregiver to stay at home, thus impeding the child's educational success and the adult caregiver's professional success. Harlem Hospital, in New York City, has engaged in intensive community outreach that has mitigated the burden imposed by this condition. If our aim is to follow Harlem Hospital's lead on a larger scale, it will be better served by educating doctors about the strong relation between poverty and environment than by educating them about the relatively weak relation between skin color and treatment preferences. These alternative approaches could have received more consideration in this engaging book.

Peter B. Bach, M.D.

Memorial Sloan-Kettering Cancer Center
New York, NY 10021

**STORIES IN THE TIME OF CHOLERA:
RACIAL PROFILING DURING
A MEDICAL NIGHTMARE**

By Charles L. Briggs, with Clara Mantini-Briggs. 430 pp., illustrated. Berkeley, University of California Press, 2003. \$34.95. ISBN 0-520-23031-0.

STORIES IN THE TIME OF CHOLERA (NOT TO be confused with the novel *Love in the Time of Cholera*, by Nobel laureate Gabriel Garcia Marquez) is a sociological analysis of a cholera outbreak in the delta region of the Orinoco River in eastern Venezuela in 1992 and 1993. One of the authors, Charles L. Briggs, Ph.D., trained in social anthropology and sociolinguistics and is professor of ethnic studies at the University of California, San Diego. He has worked in Venezuela since 1986 and is conversant in Warao, an indigenous language. He met his wife, coauthor Clara Mantini-Briggs, M.D., M.P.H., during the epidemic's early stages. Together they visited the delta, conducted interviews, evaluated health conditions, and collected graphic narratives (e.g., "We were shitting, the guy was shitting, shitting, shitting, shitting, and when he shitted again he passed out. 'I'm going' — those were his last words"), which provide the substance of this profusely footnoted, illustrated, and heavily referenced book. The authors' thrust is that "medical profiling" is both racist and "a prescription for institutional failure and human suffering."

Having worked in cholera epidemics in the Philippines (1961), Calcutta, India (1962), Vietnam

(1963), Thailand (1966), and Taiwan (1967), I am keenly aware of the difficulties in controlling outbreaks and delivering medical care when resources are limited or lacking. In fact, cholera occurs in epidemic proportions only under those conditions. The current great pandemic of cholera, widely regarded as the seventh, started in 1961 and entered the Western Hemisphere, for the first time in a century, by means of an explosive outbreak in Peru in January 1991. (Many of us had predicted earlier [Finkelstein RA. Cholera. *CRC Crit Rev Microbiol* 1973;2:553-623] that cholera would enter South America from Africa — not from the west — in the 1970s.) By year's end, Peru had reported more than 300,000 cases. The case fatality rate was less than 1 percent, owing to early and effective medical intervention. (Untreated, cholera may kill as many as 70 percent of people who have it, and the case fatality rate is many times higher in Africa.) Cholera then metastasized through South America and Central America, following routes of human transportation, and arrived in Venezuela, as reported in the book, in November 1991. It quickly reached the delta region of the Orinoco River, where it was encountered by Briggs, and where, he says, "nine of my closest friends had died. The survivors were terrified." It can now be stated categorically that deaths from cholera are due to failures in health care delivery. Why these failures occur is a major subject of the book.

Treatment consists of vigorous replacement of the fluid and electrolytes that are lost in the voluminous cholera stools. Replacement can be performed either intravenously (when required) or orally (with solutions of oral rehydration salts [ORS] or their locally prepared equivalents). The "cholera cot" (a canvas cot with a hole cut in it and situated over a bucket) is a useful device to "keep score."

The authors accuse public health officials of failing to inform and deliver health care to the indigenous population, or *indígenas*, as opposed to the upper-class, nonindigenous people, or *criollos* — the "unsanitary" as opposed to the "sanitary" citizens. The authors regard this failure as a manifestation of racism, imply that it was intended to deflect the blame for the outbreaks from the institutions to the victims, and suggest that it contributed to the persistence of cholera in Venezuela. The *indígenas* were completely ignorant about cholera. They had no idea how to treat it (vernacular medicine [i.e., shamanism] was totally ineffective) or how to prevent it (they had no concept of the germ theory or of point-of-use water purification, which could have been

decisive), and panic ensued. They descended on cities, where they were rejected or incarcerated. The authors claim that the victims were regarded as the cause of the outbreak by public health authorities and the press. The equation “barrio = poor = dirty = cholera” is, unfortunately, too true.

Cholera has always been regarded as a social disease. It is vastly underreported. Countries do not like to report it because of its commercial impact — they prefer to blame it on their neighbors — and because of variations in the definition of a case. The authors recognize this problem but offer few helpful suggestions. Rather, they criticize administrators, health care deliverers, and epidemiologists, and they take a long time to do it.

Richard A. Finkelstein, Ph.D.

University of Missouri School of Medicine
Columbia, MO 65212
rafinkelstein@msn.com

NEIGHBORHOODS AND HEALTH

Edited by Ichiro Kawachi and Lisa F. Berkman. 352 pp., illustrated. New York, Oxford University Press, 2003. \$58.95. ISBN 0-19-513838-4.

WE USED TO THINK WE KNEW HOW TO make populations healthier: start by safeguarding the quality of air, water, and food and providing for the proper disposal of human and industrial waste; next, ensure the availability of adequate medical care. More recently, we came to know the importance of healthy forms of behavior — abstaining from smoking, drinking alcohol in moderation and not before driving an automobile, eating wisely, participating in regular physical activity, and engaging in prudent sexual practices.

But recent information has complicated our understanding of health. Even when one controls (as best one can) for differences in medical care and behavioral risk factors, huge gradients persist in overall and disease-specific mortality rates according to income, educational status, job category, and neighborhood. How and why these gradients occur and what, if anything, can be done to reduce them are some of the critical questions facing people who are interested in the health of the public, the genetic revolution notwithstanding. Lisa Berkman and Ichiro Kawachi of the Harvard School of Public Health are leaders in expanding our view of health, first with their important book entitled *Social Epidemiology*

(New York: Oxford University Press, 2000) and now with *Neighborhoods and Health*. In *Social Epidemiology*, they provided a comprehensive review of the ways in which social context influences behavior as well as a broad range of health outcomes. Why are income and educational status so important? How do factors such as jobs, discrimination, neighborhoods, and social cohesion influence health, and what methods can be used to improve our understanding of these complex relations?

Neighborhoods and Health drills deeper into one variable — neighborhoods. Using the same format as they used in *Social Epidemiology*, Kawachi and Berkman have assembled a multidisciplinary group of authors that includes epidemiologists, sociologists, demographers, statisticians, clinicians, and medical geographers. The book of 15 chapters is divided into four parts. The first two chapters review previous research, making a strong case regarding the way in which neighborhoods influence health (e.g., through differential exposure to health care, stressors, employment, transportation, stores, recreation, crime, “incivilities” such as litter and graffiti, policing, environmental hazards, and social networks). A particularly sobering finding is that the age-, race-, and sex-adjusted relative risk of death associated with living in a poor area is 1.7.

The next section (chapters 3 through 8) focuses on the methodologic complexities of research on neighborhoods. In short, this kind of research requires complex, multilevel analytic techniques that may prove difficult to translate for policy analysts.

Chapters 9 through 11 summarize evidence that links neighborhoods to specific health outcomes — infections, infant health, and asthma. We learn, for example, that mothers in poor neighborhoods in Boston who keep children indoors because they fear violence thereby increase their children’s likelihood of exposure to respiratory viruses that trigger asthma attacks.

The final section illustrates crosscutting themes such as residential segregation according to race and class, social interactions, aging, and the relevance of neighborhood to social policy. The finding that was the most striking to me was the quantification of segregation according to race. The probability that a poor person lives in a high-poverty neighborhood (with a poverty rate of at least 40 percent) is only 6 percent among whites, as compared with 22 percent among Hispanics and 34 percent among blacks.

It is difficult to generalize from *Neighborhoods and*

Health, because much of the research comes from cities in the eastern United States, and the populations are mostly black, with minimal inclusion of groups such as Hispanics and Asians. This is especially important, since these groups have such different health profiles from blacks of similar economic and educational status.

Who should read this book? People who are unfamiliar with the subject should review the early parts and the final four chapters to get a sense of the book's relevance and complexity. Clinicians caring for indigent populations can expand their understanding of the effects of neighborhoods on health by skimming through chapters 9 through 11. People who wish to work in the field need to be immersed in the difficult chapters on methodology.

The book contains its own summary: "The field . . . is still at an early stage. . . . Much remains to be done before this research fulfills its potential in improving population health."

Steven A. Schroeder, M.D.

University of California, San Francisco
San Francisco, CA 94143-1211

Book Reviews Copyright © 2003 Massachusetts Medical Society.

CORRECTIONS

Prevention of Recurrent Preterm Delivery by 17 Alpha-Hydroxyprogesterone Caproate (June 12, 2003;348:2379-85). On page 2379, the list of authors should have included Steven Gabbe, M.D., of the Vanderbilt University Medical Center, Nashville.

Extended Follow-up of Long-Term Survivors of Childhood Acute Lymphoblastic Leukemia (August 14, 2003;349:640-9). On page 642, in the last column of the first row of Table 1, the summary of central nervous system irradiation should have read, "Patients received 5 or 12 Gy of craniospinal irradiation in studies 1, 2, and 3; patients received no irradiation in study 4," rather than "None," as printed.

NOTICES

Notices submitted for publication should contain a mailing address and telephone number of a contact person or department. We regret that we are unable to publish all notices received. Notices also appear on the Journal's Web site (www.nejm.org/meetings). The listings can be viewed in their entirety or searched by location, month, or key word.

7TH INTERNATIONAL CONFERENCE ON GERIATRIC NEPHROLOGY AND UROLOGY

The conference will be held in Atlanta, Oct. 9–12.

Contact Nancy Kutner, 2576 Vaughandale Circle., Gainesville, GA 30506; or call (678) 316-7771; or e-mail nkutner@emory.edu; or see <http://www.cha.emory.edu>.

IMEDEX ONCOLOGY

The following conferences will be held: "Difficult to Treat Mood and Anxiety Disorders" (Washington, D.C., Oct. 17 and 18); "In-Focus — Forum de Infeccoes Fungicas na Pratica Clinica (in Portuguese and Spanish)" (Sao Paulo, Brazil, Oct. 31 and Nov. 1); "1st Annual Conference: Perspectives in Palliative Care" (Sitges, Spain, Nov. 6–8); "14th International Conference: Challenging Cases in Urology" (Miami, Feb. 19–21); and "Focus on Fungal Infections 14" (New Orleans, March 17–19).

Contact Heather Drew, Imedex, 70 Technology Dr., Alpharetta, GA 30005; or call (770) 751-7332; or fax (770) 751-7334; or e-mail h.drew@imedex.com; or see <http://www.imedex.com>.

A COMPREHENSIVE BOARD REVIEW IN HEMATOLOGY AND MEDICAL ONCOLOGY

The conference will be held in Houston, Oct. 8–13. It is jointly presented by the University of Texas M.D. Anderson Cancer Center and Baylor College of Medicine.

Contact the University of Texas M.D. Anderson Cancer Center, CME/Conference Services — Unit 131, 1515 Holcombe Blvd., Houston, TX 77030-4009; or call (713) 745-0083; or e-mail meetings@mdaisd1.mdacc.tmc.edu; or see <http://www.mdanderson.org/conferences>.

NEW ENGLAND EDUCATIONAL INSTITUTE

The "11th Annual Santa Fe Symposia" will be held in Santa Fe, N.M., Oct. 10–26. The following three-day mental health symposia will be held: "Spirituality: The Missing Dimension in Therapy," "Conquering Anxiety Disorders," and "Mindfulness Meditation: Exploring the Self" (Oct. 10–12); "Existential Issues in Psychotherapy: Radical Acceptance and Renewal," "Angry and Aggressive Behavior: A Life-Span Treatment Approach," and "Spirituality and Psychology" (Oct. 17–19); and "Mindfulness-Based Cognitive Therapy," "Keeping Your Soul Alive," and "The Nature of Autism and Asperger's Disorder" (Oct. 24–26).

Contact New England Educational Institute, 92 Elm St., Pittsfield, MA 01201; or call (413) 499-1489; or fax (413) 499-6584; or e-mail educate@neei.org; or see <http://www.neei.org>.

UNIVERSITY OF ILLINOIS AT CHICAGO COLLEGE OF MEDICINE

The following meetings will be held: "Speciality Review in Neonatology/Perinatology" (Oak Brook, Ill., Oct. 13–17) and "28th Midwinter Symposium on Practical Surgical Challenges in Otolaryngology" (Snowmass Village, Colo., Feb. 16–20). They are sponsored by the Department of Pediatrics and the Department of Otolaryngology—Head and Neck Surgery, respectively.

Contact UIC Conferences and Institutes (MC 117), 750 S. Halsted St., Room 214, Chicago, IL 60607; or call (312) 996-5225; or e-mail uicci@uic.edu; or see <http://www.uic.edu/depts/ci/>.

5TH ANNUAL PEDIATRICS CONFERENCE

The conference will be held in Wilmington, N.C., Oct. 16 and 17. It is sponsored by the Coastal Area Health Education Center (Coastal AHEC) and the University of North Carolina at Chapel Hill School of Medicine.

Contact Karen Coats, Coastal AHEC, P.O. Box 9025, Wilmington, NC 28402-9025; or call (910) 343-2516, extension 325; or fax (910) 762-9203; or e-mail karen.coats@coastalahec.org; or see <http://www.coastalahec.org>.

AO NORTH AMERICA CRANIOMAXILLOFACIAL SURGEON COURSE

The course will be offered in Philadelphia, Oct. 11 and 12, and in Cleveland, Nov. 22 and 23.

Contact AO North America, CME Office, 1690 Russell Rd., Paoli, PA 19301; or call (800) 769-1391.

DYSYPHAGIA RESEARCH SOCIETY

The "12th Annual Meeting" will be held in San Francisco, Oct. 2–4.

Contact Pam Vinje, International Meeting Managers, 4550 Post Oak Place, Suite 342, Houston, TX 77027; or call (713) 965-0566; or fax (713) 960-0488; or e-mail imm@meetingmanagers.com.