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HEALTH CARE –
Racial Disparity

Does unequal treatment really have roots in racism?

Raw numbers raise questions about conclusions of heart study

By Kathleen Fackelmann
USA TODAY

The issues of race, sex and medical care exploded into the public view recently when a scientific study suggested that, when it comes to heart care, blacks and women get unequal care.

That study indicated that blacks and women were less likely to get a standard test for heart disease.

But some experts say the study's authors exaggerated the differences in care. Black women alone did get less care, but that finding could have been a fluke, those experts say.

Others say discrimination in the doctor's office is real.

"All of the studies looking at race and sex show that there is a bias," says B. Waine Kong, chief executive officer of the Association of Black Cardiologists in Atlanta.

The uproar began when Kevin Schulman, then a researcher at Georgetown University Medical Center in Washington, D.C., and his colleagues published a study in the February *New England Journal of Medicine* (*NEJM*).

Media outlets, USA TODAY included, largely reported the findings in the same way, saying that blacks and women with chest pain were about 40% less likely to get a common test for heart disease than whites or men. The stories suggested that the unequal treatment had its roots in gender and/or racial bias.

When Steven Woloshin of the Veterans Affairs Outcome Group, part of the federal Department of Veterans Affairs, in White River Junction, Vt., saw the story on ABC's *Nightline*, he was "disturbed by the terrible indictment of the way doctors were practicing medicine," he says.

The story; the rebuttal

Woloshin, Lisa Schwartz and their colleagues at the VA took a closer look at the study and published a rebuttal in the July *NEJM*.

To understand the rebuttal, first consider the original article. In that study, Schulman and his colleagues videotaped eight actors and actresses describing chest pains from an identical script. Schulman's team asked more than 700 doctors to evaluate the tapes and recommend a course of action. Most of the doctors were white men, though there were blacks and women.

In the videotape, two black men, two black women, two white women and two white men pose as patients. The actors and actresses used the same gestures to describe chest pain. To eliminate other potential sources of bias, the eight had identical jobs, health insurance and addresses. They even dressed alike.

In each case, doctors decided whether the patient should be sent to a lab for a cardiac catheterization. In that procedure, a doctor snakes a thin plastic tube up an artery from the leg to the heart. Once in place, the catheter helps the doctor see whether fatty goo called plaque has plugged up the arteries that supply the heart with blood. Such fat-choked arteries can put people at risk of a heart attack.

Schulman and his colleagues determined that the odds of a physician referring blacks and women to the cath lab were 40% less than the odds of sending white men for the heart test. The findings suggested that discrimination played a role in the lower referral rate.

But in their July rebuttal, Woloshin and his colleagues say the 40% conclusion is misleading. The raw data, broken down by sex and race, tell a slightly different story.

Those raw numbers show that white men, black men and white women were referred for the heart test at approximately the same rate — 90%.

But black women were referred to the cath lab about 78% of the time.

Richard Stein, a cardiologist at the Health Science Center at the State University of New York at Brooklyn, says the difference is quite small and could have reflected chance.

Furthermore, Stein and the Woloshin group contend that the 90% figure is extraordinarily high and may not reflect the best in health care. Cardiac catheterization poses some risks to the patient, including a rare chance that the procedure itself will lead to a heart attack, they say.

Schulman doesn't quibble with the argument that the odds ratio might have misled people.

"The fact remains that we were doing a valid statistical test," says the statistician on the study, Jesse Berlin of the University of Pennsylvania School of Medicine in Philadelphia. The 40%, unlike the raw numbers, tells researchers — the intended audience for the study — that the difference in referral rates is statistically significant, he says.

Readers of the study never saw those raw numbers, however. They were edited out by the reviewers at *NEJM*. In the same issue as the rebuttal study, the editors say: "We take responsibility for the media's overinterpretation of the article. We should not have allowed the use of odds ratios in the abstract."

Schulman stands by the main thrust of the article: that blacks, in this case black women, do receive cardiac care that is different from that given to whites with the same symptoms. Schulman and others say many studies have suggested that blacks and women get less aggressive treatment for heart disease, as well as other health conditions.

Many black Americans, including heart specialists, do attribute the unequal access to discrimination.

"I think that physician bias is something that is real," says Paul Douglass, a cardiologist at the Morehouse School of Medicine in Atlanta. Physicians are no better or worse than the rest of society, he says. The prejudice that exists in the USA as a whole can be found among physicians as well, he says.

"There's still a lot of unconscious racism," says Charles K. Francis, president of the Charles R. Drew University School of Medicine in Los Angeles. Many physicians don't realize they are judging a patient by skin color or sex, he says.

The insurance issue

The compelling aspect of Schulman's study is that it eliminates the potential bias doctors may have in favor of those who have health insurance, Douglass says. In the past, experts attributed the lack of referrals to a problem with health insurance. That suggests that people without health insurance might not get a heart test because doctors and hospitals are reluctant to provide an expensive service that might end up as bad debt.

In this study, all the actors and actresses had medical coverage as well as identical jobs and addresses. Still, Schulman notes, physicians rated the black patients as having lower incomes than the white patients.

How do the VA doctors explain that the black actresses in the study were referred less often?

They don't have the answers but say that the study cannot be used to support the conclusion that racism is driving the referral rates. There are many other reasons why physicians might be reluctant to send a patient to the cardiac cath lab, Stein says.

"It would be a great surprise to me that racial prejudice plays a role in those decisions," he says. For example, if black patients suffer from several health problems, a doctor might not order a risky cardiac catheterization.

Woloshin says the Schulman study's flaws make it impossible to draw any broad conclusions about race, sex and heart care.

"It's hard to say that this study adds much to the debate," he says.

Woloshin and his colleagues say the study fuels a hostile atmosphere between patients and physicians in which "blacks and women may be more likely to ascribe disappointing interactions with their physicians to prejudice rather than to other plausible factors," such as poor people skills.

Douglass, however, concludes: "You can argue with statistics all day. ... We have to face the reality of our situation: There is a gender and racial bias."

Lack of parking creates lots of stress

Many cities are enjoying revivals in their downtowns. People arrive to work, live and play — if they can find a spot for their car.

By Haya El Nasser
USA TODAY

In 1974, Joni Mitchell bemoaned the urbanization of America when she sang: "They paved paradise and put up a parking lot."

Today, the same lyrics would draw cheers from people who visit, work and live downtown. To them, more parking lots would be paradise.

The resurgence of downtown neighborhoods is creating an unprecedented parking crunch in many cities. More people are choosing to live in urban centers and need parking for their cars. New stadiums and entertainment complexes are attracting carloads of visitors. And residential and office buildings are going up on lots that once were parking lots.

By midmorning, "Lot Full" signs are everywhere in thriving cities such as Chicago, Seattle, Denver and Washington. Following the law of supply and demand, parking prices are doubling. People are paying more money to park blocks away from their destinations. There's such a crunch that some businesses are scheduling meetings away from downtown to appease clients who gripe about parking.

"There used to be an ocean of parking here," says Alan Gottlieb, who works for the Piton Foundation in downtown Denver.

While cities are rejoicing the revival of their downtowns, they're scrambling for solutions to this latest planning nightmare: How to keep people coming when there's no place to park.

"There's simply not enough space," says Tom Reilly, assistant director of parking management in Denver. "We went from basically zero to 19,000 people living downtown. The problem is that people move downtown but still keep three cars."

Cities are organizing task forces, commissioning studies, beefing up parking requirements for new construction, promoting the use of mass transit, forcing employers to offer carpool incentives and extending parking-meter hours to encourage a high turnover.

▶ Chicago's downtown population has doubled every 10 years and is now at 100,000. Parking spots number 87,000.

"We're encouraging as much use of public transportation as possible," says Becky Carroll of the city's planning and development department. The city is doing an extensive review of traffic and parking.

▶ In Denver, the biggest surface parking lot downtown disappeared when a mall was built nine years ago. City officials encourage visitors and workers to park farther away and hop on shuttle buses.

Denver's downtown district has about 65,000 parking spaces, but 120,000 people work in the area. Committees have been studying the problem for years. The best solution is more mass transit, Reilly says, "but it's incredibly expensive."

What's cheaper for the city but costlier for visitors are the longer-running meters (until 10 p.m.) that are popping up throughout "LoDo," Denver's hip lower downtown neighborhood.

▶ Almost half a million cars go in and out of downtown Seattle every day. But there are only about 54,000 off-street parking spaces and fewer than 5,000 on-street.

"It's a real challenge," says Liz Rankin of Seattle's transportation department. Some people want more short-term parking. Others want more long-term parking. Retailers and downtown businesses want parking, period. And many want less parking and more mass transit.

"How do you meet parking needs and also encourage people to use alternatives to driving?" Rankin asks.

In 1991, Washington state required large companies to offer incentives for car pooling or use of public transit. Seattle requires building owners to do the same. In a city where daily parking rates have soared to as much as $20, the most popular car pool incentives are parking discounts.

"Nearly every parking garage that offers them has a waiting list," Rankin says.

▶ A report on the parking pinch in Washington, D.C., is expected any day now. Already, the city plans to run shuttles to and from some of the city's hot spots, including the National Mall, Georgetown and Capitol Hill.

The goal is to get tourists to fan out through various city neighborhoods without their cars rather than clog up traffic and parking. But Douglas Patton, deputy mayor for planning and economic development, hopes downtown workers will use the shuttles, too.

"Tourism is up. People want to live in the District. We like that, but with that goes more cars," he says. "But I'd rather be dealing with that than a scarcity of cars and tourists and people working here and living here — and all the loss of revenue that would come with that."