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Commentary: Race and medicine: Not all differences are disparities

Paul Kurlansky, MD

Understanding and addressing disparities in health care is a national and professional priority. For nearly 2 decades, Congress has mandated the Agency for Healthcare Research and Quality to generate annual National Healthcare Quality and Disparities Report based on more than 250 measures of quality and covering a broad range of health care services and settings.¹ A query of PubMed for “health disparities” will yield more than 85,000 results with a logarithmic acceleration over recent years (Figure 1).² Understanding racial differences in medicine is particularly challenging. Race is a social construct inadequate to describe the distribution of genetic variation in our species.³ Therefore, distinguishing scientific from social and political determinants of health can be a difficult—but very important—task. Political solutions to scientific

CENTRAL MESSAGE

Careful analysis of racial differences in presentation and outcome of surgical procedures is essential to better understand the specific role of race in surgical disease.

problems rarely succeed, but the search for the scientific basis of political problems is a similarly futile undertaking. Although surgical care focuses on a very specialized segment of the broad spectrum of health care, operative decisions and outcomes are inextricably tied to the general environment in which they occur.

It is in this context that the carefully constructed analysis of mitral valve surgery in the state of Michigan reported in this issue of the *Journal* presents an important contribution to our understanding of racial disparities in surgical care.⁴ Leveraging the robust clinical data from the Society of Thoracic Surgeons database shared among all sites performing cardiac surgery in that state, the authors explore racial differences in the preoperative characteristics,

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FIGURE 1. PubMed citations for query of “health disparities.”

procedure type, and outcomes of mitral valve surgery over the most recent decade. Indeed, there were quite dramatic differences in patient presentation, procedure performed, and outcomes among different racial groups, stratified as White, Black, and Other (using the Society of Thoracic Surgeons definition of self-identification). However, when using carefully constructed and appropriately applied statistical modeling that accounted for differences among patients as well as hospital as a random effect, the authors found that race was not independently associated with either the decision to perform mitral valve repair nor with mortality or major surgical complications. One might argue that by accounting for clustering within surgical sites, the authors may have “overadjusted” for the possibility that Black patients may have been concentrated in hospitals with worse risk-adjusted outcomes. However, the propensity score-weighted assessment performed as a sensitivity

analysis, which did not adjust for hospital, essentially rebuts this theoretical possibility.

The findings of this report are extremely important. What they suggest is that (1) there are large differences among races in selection of operation and surgical outcomes for mitral valve disease; and, that (2) those differences are not specifically due to race but rather to patient presentation. The *Oxford English Dictionary* defines “disparity” as “a difference, especially one connected with unfair treatment.”⁵ According to this construct, it would seem that not all differences constitute disparities. Unfair treatment is clearly unacceptable in any medical context. However, the carefully constructed information provided suggests that future focus is best directed not so much toward the selection and conduct of surgery but rather toward the broader health care environment in which those endeavors are being made.

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