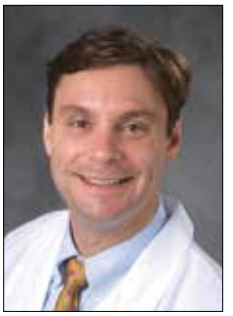
# Addressing the Racial Gap in Health Care



I was disheartened when I read the article "The Black Mortality Gap, and a Document Written in 1910" in the August 30 edition of *The New York Times.* I am fully aware that the survival of Black Americans has long been worse than that of White Americans, and that many factors, including access to care and socioeconomic differences, have driven this mortality gap. But what was disheartening to me was how a well-intentioned policy implemented 100 years ago inadvertently contributed to this divide.

To summarize, the article described the poor state of medical training and oversight at the turn of the 20th century. Because of inadequate credentialing and standards, medical schools were flooding the field with inadequately trained physicians, which led to substandard care in many parts of the country, particularly for Black patients receiving segregated care in the South. The Flexner Report summarized this sad state of affairs in 1910 and went on to suggest a number of solutions, including raising standards for medical schools and limiting the number of students. No federal support was provided to help medical schools meet these requirements, however. As a result, the report led to the closure of five of the seven historically Black medical schools at a time when medical education was largely segregated, leaving just Howard University College of Medicine and Meharry Medical College to train Black physicians.

If we fast forward to our current day, we can see the remnants of these policies still having an effect more than 100 years later. Although 13% of the US population is Black, just 5% of physicians in this country are Black, and a greater percentage of Black physicians are in primary care rather than in higher-paying subspecialties. Given this reality, it should not be surprising to see the difference in cancer outcomes between Black and White patients.

Although it will take years to rectify the disparity between Black and White physicians, we need to address these concerns in real time. To start, we can and should consider the perspectives of our Black patients and strive to build more multiracial care teams in our health care environments. At Duke, that is our goal. Although our roster of physicians and nurse practitioners may not be as diverse as we would like, our overall staff certainly is, including schedulers, check-out staff, medical assistants, and patient navigators. All of these professionals are essential parts of our care team, and we have begun to restructure our workspace and workflow to combine the entire team into a patient-centered focus. Our hope is that such workflow consolidation will result in greater interpersonal respect and team resiliency, with more visible multiracial interactions around the patients we are serving. The goal is to allow all of our patients to feel more comfortable at our facility.

Why might this be especially critical today? On July 22 of this year came a relatively shocking report by Bernstein and colleagues, published online in *JAMA Oncology*, describing how COVID-19 has affected the use of prostatectomy to treat patients in the Philadelphia area with newly diagnosed prostate cancer. This retrospective study looked at men receiving care for nonmetastatic prostate cancer from March to May of 2020, and from March to May of 2019 (pre-pandemic). They found that Black men were significantly less likely than White men to undergo a prostatectomy during the pandemic (1 of 76 [1.3%] vs 50 of 193 [25.9%], respectively; $P<.001$), whereas prostatectomy rates had been comparable between the two groups before the pandemic (17 of 96 [17.7%] vs 54 of 282 [19.1%]; $P=.75$). Although one could argue that prostatectomy is not an immediate need, the effects of this discrepancy in health care could be long-lasting as the pandemic drags on. These statistics, and others like them, reflect realities that are hard to recognize in our individual practices but are important for us to acknowledge. Although change is daunting, the research shows where we need to place our efforts to address these disparities.

Sincerely,

Daniel J. George, MD