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From Awareness to Action: Understanding and Addressing Health Disparities

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ABSTRACT

In the United States, marginalized groups consistently face barriers to healthcare services necessary for maintaining quality of life and achieving positive health outcomes. Health disparities can be defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been disadvantaged by their social or economic status, geographic location, or environment" (CDC, 2008). With input from insightful interviews, this article seeks to investigate specific challenges faced by marginalized groups in the healthcare setting and provide potential solutions to reduce health disparities.

KEYWORDS: health disparities, health equity

In the United States, marginalized groups consistently face barriers to healthcare services necessary for maintaining quality of life and achieving positive health outcomes. Health disparities can be defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been disadvantaged by their social or economic status, geographic location, or environment" (CDC, 2008). With input from insightful interviews, this article seeks to investigate specific challenges faced by marginalized groups in the healthcare setting and provide potential solutions to reduce health disparities.

Our first interview, with Dr. Lauren Freeman, concentrated on epistemic microaggressions. Dr. Freeman, an Associate Professor in the Department of Philosophy at the University of Louisville, has numerous publications detailing epistemic and other injustices in medicine. Through a multidisciplinary approach, Dr. Freeman's research explains how members of marginalized groups experience oppression in subtle and also less subtle ways within healthcare contexts. As a foundational concept, Dr. Freeman coined the term epistemic microaggressions and defines them as either "intentional or unintentional, verbal or gestural slights made by healthcare\ professionals that either ignore, dismiss or otherwise fail to recognize claims that patients make about their bodies or themselves." Crucially, *epistemic microaggressions* affect members of marginalized groups in their capacity as knowers (and here, as knowers of their own bodies). Having one's claims taken seriously by others is central to what it means to be human. As such, what clinical impact may epistemic microaggressions have on patient outcomes, given that medical diagnoses, treatments, and care procedures very often require the first-personal knowledge that patients have of their own bodies?

Consider this: Black people are incorrectly thought to have higher pain thresholds than their White counterparts (Hoffman et al., 2016). Moreover, Black patients' health concerns and claims to pain are dismissed with far more frequency than those of White patients (ibid.). This phenomenon is in part a consequence of epistemic microaggressions (as well as other oppressive practices) that do not give Black patients the credibility or knowledge status that white patients are given. In the study by Hoffman et al. (2016) that looked at differences in care based on perceived racial differences, White patients are given a more thorough evaluation and more adequate treatment recommendations. It is instructive to see this clinical interaction in the context of a study where medical students and residents were asked to provide pain ratings and treatment recommendations for both a Black and White patient. This study also measured beliefs about biological differences between Black and White people by asking participants to rate statements such as "Black people's nerve-endings are less sensitive than White people's nerveendings" (Hoffman et al., 2016). Hoffman et al. (2016) found that half of a sample of White medical students and residents endorsed such beliefs and rated the Black patient's pain as lower than the White counterparts. From this, it can be seen how implicit biases

and incorrect ideas of pain can lead to epistemic microaggressions by physicians who fail to take claims of their Black patients seriously.

Dr. Freeman emphasized that microaggressions are only "micro" when considered from the perspective of the one committing them, in other words, from the perspective of someone in a position of relative social power. They are certainly not "micro" when considered from the perspective of the recipient. She went on to say there is cumulative and enduring harm from these microaggressions in exacerbating health disparities for both the individual and their community.

To follow up this discussion, we interviewed Dr. Kim Williams Sr., Chair of the University of Louisville Department of Medicine, a cardiologist and leading voice on health equity.

Our conversation began with learning more about Dr. Williams' experiences growing up on the south side of Chicago, where his own health challenges and those of his community informed his decision to pursue medicine. To illustrate this point, Dr. Williams referenced a study conducted by the NYU School of Medicine (2019) that showed a thirty-year difference in life expectancy between Streeterville on the northside of Chicago and Englewood on the southside. What could be contributing to such a drastic difference in health outcomes between neighborhoods in the same city? Dr. Williams emphasizes three points: poor access to care, access to poor care, and accessing care poorly.

Poor access to care encompasses challenges such as a lack of affordable health coverage and limited transportation to healthcare facilities. Despite increased regulatory attention towards improving affordable health insurance in the form of the Affordable Care Act, millions of Americans are still uninsured. In an emergency, ambulances may be able to transport patients to the emergency room, where care cannot be legally denied; however, follow-ups are rare because these same patients may have poor access to insurance or a lack of reliable transportation.

Even assuming patients are able to receive some form of healthcare, it is not necessarily "quality" care. Access to poor care, either due to healthcare professionals not adhering to published guidelines or implicit biasrelated implementation of those guidelines, is a critical contributing factor to some health disparities. As a key author on medical guideline committees, and during his work for the American Heart Association (AHA) and American College of Cardiology (ACC), Dr. Williams noticed that surveys conducted on physicians repeatedly showed they were not following the written guidelines. He also provided us with specific clinical examples of implicit biases, such as in a study investigating physicians' recommendations for cardiac catheterization. In this study published in the New England Journal of Medicine (NEJM), 8 study participants were divided by race, sex, and relative age. They were instructed to say exactly the same thing in a scripted recorded interview, which was then shown to 720 total physicians who then made recommendations for those patients' care. The results were quite revealing.

The "analysis of race–sex interactions showed that black women were significantly less likely to be referred for catheterization than white men (odds ratio, 0.4; 95 percent confidence interval, 0.2 to 0.7; P=0.004)" (Shulman et al., 1999). From this, it is clear that clinical data alone may not influence recommendations for managing chest pain. In fact, in this study, race and sex are independent predictors of how physicians might provide care for patients with chest pain. These disheartening results highlight the importance of addressing potential implicit biases, not just for diagnostic testing, but for overall health outcomes.

The final aspect of this triad is accessing care poorly. According to Dr. Williams, a patient might have a healthcare provider who is following the guidelines, sympathetic to their plight, communicates effectively, and simplifies access to required medications or other treatments. However, patients could still experience adverse health outcomes due to low health literacy. The Center for Disease Control (2022) defines personal health literacy as the "degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others." Education, race, income, age, and geographic location within the United States are all contributing factors to low health literacy, with heavy influence from numerous systemic problems. Limited health literacy has been associated with increased hospitalization, limited use of preventative health services, and overall poor health outcomes (Berkman et al., 2004). The dire consequences of lower health literacy cannot be ignored, as it has the potential to exacerbate existing health disparities and widen the gap between those who have access to quality healthcare and those who do not.

To gain further insight into health literacy and education, our final interview was with Ms. Zoha Mian, a medical student at the University of Louisville School of Medicine. She is a co-founder of Grow502, a student-run non-profit organization that aims to highlight health disparities in Louisville, Kentucky. Ms. Mian and the other co-founders looked at the Louisville HealthEquity report that examines health determinants in Louisville from a public health perspective. Using this information as a blueprint, Grow502

created a fourweek curriculum focusing on four different health disparities: infant mortality, mental health, stroke, and diabetes. They also incorporated an education, advocacy, community engagement and creative media component in the curriculum to increase both community awareness and advocate for change. Ms. Mian's participation in Grow502 is informed by her experiences as both a medical student and Louisville native; she described specific health disparities she noted in the community.

Ms. Mian discussed lead poisoning as an example, explaining that the lead levels in the West End of Louisville are dangerously high. Many in those areas live in homes built in the early 1980's which have not all been tested for lead. She further discussed how kids come into clinics and hospitals for chronic constipation or cognitive dysfunction attributed to high lead levels in their system. Similarly, many children in the West End also have severe asthma, particularly in an area called Rubber Town, where many factories are present and contribute to air and water pollution. Ms. Mian also mentioned that infant mortality rates are very high in Louisville, especially amongst the poor, Black population. This could be attributed to limited access to care, transportation issues, and provider biases, all of which are critical points previously brought up by Dr. Williams that warrant further study for workable solutions.

Another critical point addressed by both Dr. Williams and Ms. Mian are food deserts. Ms. Mian delved into this issue, noting there are considerably fewer grocery stores in West Louisville, where the demographic is largely of a lower socioeconomic status. In fact, out of 20 Kroger locations in Jefferson County, the largest county in Louisville, only two locations are in the West End. This scarcity of reliable, healthy food pushes residents towards unhealthier options located at nearby gas stations, Dollar Trees, and fast food chains. Lack of access to affordable, nutritious food sources can contribute to increasingly adverse health outcomes, especially among already disadvantaged populations. These disparities perpetuate cycles of poor health that can pass through generations.

We have addressed some of the challenges contributing to health disparities in the United States, but it begs the question: what can be done? All three of our interviewees provided unique perspectives and addressed different aspects of the problem. When looking at solutions, we found some common threads between them: advocacy, community engagement, and education.

Dr. Lauren Freeman began our discussion on solutions by talking about her collaborations with healthcare providers via workshops here at the University of Louisville and the Norton Hospital system. She emphasized a transdisciplinary approach, working not just across different disciplines, but also across different fields. By bringing together professionals with unique perspectives, such as a healthcare provider's clinical expertise and a bioethicist's ethical considerations, we can develop a more nuanced and comprehensive approach to complex problems like health disparities.

This discussion transitioned to a conversation on education and its importance in changing the current healthcare landscape. Both Dr. Freeman and Zoha Mian stressed the crucial role of social justice and equity in medical education. This involves not only integrating these concepts into the medical school curriculum, but also addressing implicit biases among healthcare providers while in training. It is vital for future healthcare providers to be aware of their own potential biases and to understand how these biases can impact their interactions with patients.

Improving health literacy in the general population, especially amongst the most vulnerable groups, is another important facet to address. This allows people to advocate for themselves and be more active in maintaining their personal health. Ms. Mian talked about how Grow502 hosted virtual events in which they would present case files and talk about the epidemiology and pathology of a certain disease. Furthermore, through their curriculum, they brought in experts on these issues and connected those experts to students, and to other community members. This approach not only educates people on understanding and maintaining their personal health, but also fosters connections and engagement within the community.

To build on that engagement, Dr. Freeman discussed getting community and patient takeholders into positions of power and building trust with populations disproportionately affected by health crises. Meanwhile, Dr. Williams has been working to provide better access to care through his previously established programs. These programs include the Urban Cardiology Initiative in Detroit, MI, aimed at reducing ethnic heart care disparities, and the H.E.A.R.T. program (Helping Everyone Assess Risk Today), screening for heart disease and intervening with education, nutrition and lifestyle changes. Meanwhile, Ms. Mian, through Grow502, has recently hosted pop-up clinics to provide resources to the houseless community, as well as clinics for COVID vaccination, dental screenings, and Medicare enrollment to empower the community and bring a complicated healthcare structure to people that are most vulnerable.

The mission to address and reduce health disparities re-

quires an interdisciplinary, multi-dimensional approach that incorporates education, advocacy, and community engagement through every stakeholder - healthcare providers, medical students, patients, policymakers, and the general population. By working together to improve education, increase access to quality healthcare, and empower individuals and communities, we can create a future where health equity is a reality for all.

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