FROM THE EDITORS' DESK

Not Just Pathophysiology....

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It is always surprising to talk to medical trainees and professionals who do not appreciate the impact of socioeconomic, cultural, and linguistic factors on patient outcomes. Frequently these “non-medical” factors are as important as whether the appropriate test is performed or treatment prescribed. Unfortunately it is still common for undergraduate medical education to be focused on understanding the molecular and genetic determinants of disease with little attention paid to how the non-biologic factors influence our interactions with patients and their families. From the patient resistant to surgery because of a family member who was sterilized without consent to the homeless patient being discharged on insulin for their diabetes but with little thought to how the patient would keep the vials of medication cold, every internist must identify and deal with these issues many times each day.

Still after over a decade in practice it still surprises me how often these issues are identified. Each time I start on the wards, I orient my team and instruct them on the importance of information on socioeconomic and living situations and the questionable importance of race/ethnicity. However when the medical students present the first patient they still frequently stumble. “This is a 67 year old white male....” “I don’t know who they live with or where.” We quickly stop. How do you know their race/ethnicity? “I looked at the patient.” Where do they live and with whom? “I forgot to ask ... it wasn’t in the electronic medical record.” We then have a short discussion of why they need to ask the patient directly about race/ethnicity (assuming such information is clinically relevant), and that understanding the patient’s living situation and support network is far more important than many of the “classic” parts of the history and physical that they were taught in the preclinical years.

In this issue of JGIM, there are several articles that examine some of these issues. Williams and colleagues examined the

association of ethnic and socioeconomic biases on referral for cardiovascular procedures among senior medical students at 84 US medical schools.¹ While they did not find clinically significant ethnic or gender differences in rates of referral for procedures, they did identify an association of socioeconomic status with referrals. In this study, socioeconomic status was the strongest predictor of whether patients were referred for cardiac procedures with patients in the lowest socioeconomic group referred 43.2 % vs. 50.3 % in the highest socioeconomic group. Interestingly the medical student’s socioeconomic status was not significantly associated with their propensity to refer for cardiac procedures after adjusting for other potential confounding factors. While many health care workers are cognizant of the need to be aware of racial, ethnic, and gender biases, very few would be alert for potential biases related to the patient’s socioeconomic status. From this single study it is difficult to say whether it is true bias that affects medical trainees or whether this is an artifact of how the case vignettes were constructed. However all of us, especially those who care for patients of different socioeconomic groups, must be cognizant of potential biases that may impact what procedures and treatments we offer to our patients.

Surprisingly the authors found that both black men and women were offered cardiac procedures at significantly higher rates than white women. It is unclear why this was found. Was this due to the many recent articles demonstrating potential racial biases in medical interventions? Or that the trainees who completed the survey were inadvertently alerted to the reason for the study? It would be wonderful if the racial bias in medical decision-making were decreasing. However whatever the case we must still push forward in identifying racial, gender, and socioeconomic disparities and removing them for the sake of our patients.

In another paper, Lopez and colleagues examined the use of professional interpreters for patients with limited English proficiency at tertiary academic medical center.² Despite an Institute of Medicine report, Joint Commission standards, and a federal statute, the use of professional interpreters for those with limited English proficiency remains distressingly low. The authors found that only 34 % of patients with limited English skills had a professional interpreter visit during the hospitalization. For those who did receive an interpreter visit, length of hospital stay was significantly *longer* than other

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groups. There were no significant associations between subsequent readmissions or ED visits and interpreter visits. Thus the impact of professional interpreters on quality of care is unclear. These findings may support the contention that the use of professional interpreters is not always necessary and slows down care processes. However it is more likely that professional interpreters were used for more complex situations, while for those with more straightforward issues, medical professionals used their own limited language skills or other family members to communicate. For the sake of our patients, we must continue help our patients and their families communicate effectively with us so that they may receive the quality of care that they deserve.

Over my career I have learned much from my patients and trainees about my own biases and the need to explore patient's preferences and histories. Although progress can be slow and

uneven, with the continued focus on these areas we will improve the care that we deliver to all of our patients.

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REFERENCES

1. **Williams RL, Romney C, Kano M, et al.** Racial, gender, and socioeconomic status bias in senior medical student clinical decision-making: a national survey. *J Gen Intern Med.* 2015. doi:[10.1007/s11606-014-3168-3](https://doi.org/10.1007/s11606-014-3168-3).
2. **Lopez L, Rodriguez F, Huerta D, Soukup J, Hicks L.** Use of interpreters by physicians for hospitalized limited english proficient patients and its impact on patient outcomes. *J Gen Intern Med.* 2015. doi:[10.1007/s11606-015-3213-x](https://doi.org/10.1007/s11606-015-3213-x).