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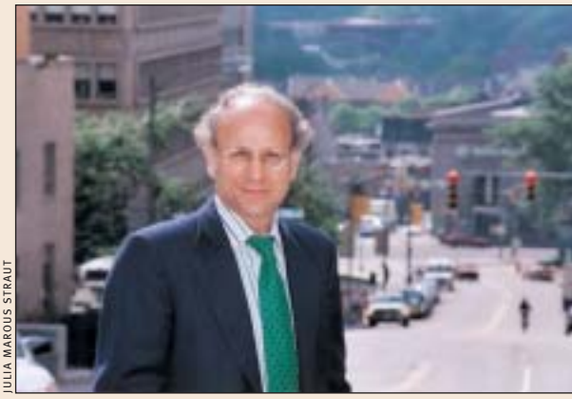
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JULIA MAROUS STRAUT

Shakespeare wrote, "One touch of nature makes the whole world kin." Indeed, whether we walk in the autumn woods or visualize the elegant architecture of cell membranes, as we become intimate with it, our awe in the face of nature is only likely to grow. At the same time, the quarrels and biases among humans seem dwarfed and petty in comparison. One would think that the world of medicine, where we are in the privileged position of not only studying nature but are invited into others' most private lives daily, would be flush in understanding and rich in fellowship. Yet we've much work to do. I'm thinking in particular about the disparities in health care and treatment outcomes experienced by racial and ethnic minorities in this country.

Some of this can be explained by genetic predisposition; certain people, and certain peoples, may respond less well to a drug, for instance. And disadvantaged minorities are well represented among the 44 million people in this country who have no health insurance and very limited access to care. But the problem is more complex and profound than can be explained by even these imposing factors. According to a recent Institute of Medicine report, racial and ethnic minorities tend to receive a lower quality of care than nonminorities, even when access-related factors, such as insurance status, age, education, and income, are controlled. Relative to whites, African Americans—and in some cases, Latinos—are less likely to receive appropriate cardiac medication, undergo coronary artery revascularization, or receive a kidney transplant. This epidemic of social disparity has also been documented in HIV treatment, diabetes, maternal and child health, mental health, cancer treatment, and rehabilitation. As it turns out, minority patients are more likely to refuse recommended care, adhere poorly to treatment regimens, and delay going to a physician. Yet the Institute of Medicine has found that such patient behaviors are unlikely to be a major cause of disparities.

It's not difficult to imagine that prejudicial behaviors are abhorrent to the values of most who choose vocations centered on caring for others. Yet studies suggest that elements of the modern health system can breed inequity. An economically driven lack of time, subtleties of communication, and an imprecise sense of a patient's culture, family, community, and environment encourage physicians to take "cognitive shortcuts" that may stem from misperceptions among the most well-intentioned of us. We can further illuminate and bring into sharp focus the root cause of inequities with a rigorous analysis that forgoes clichés. And we can begin to address inequities by providing evidenced-based medicine to all people and fostering in our students (and physicians throughout their careers) greater understanding across cultures and a more nuanced ability to communicate.

Back to the 44 million uninsured. Consider what could happen in the case of an epidemic when millions are without rapid access to care. Our early response would be compromised and the epidemic's scale greatly increased. Such thoughts are especially sobering in the wake of SARS and the possibility of the Soviet bioweapons program being sold off to rogue states. In these times, a grave note might be added to the already piercing words of the poet Langston Hughes: *What happens to a dream deferred? Does it dry up like a raisin in the sun? ... Maybe it just sags like a heavy load. Or does it explode?*

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