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Why isn't evidence based practice improving health care for minorities in the United States?

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ABSTRACT

Achieving health equity by improving the health care of all racial/ethnic groups is one of the key goals of Healthy People 2020. The implementation of evidence based practice (EBP) has been a major recommendation to achieve health equity in hopes of eliminating the subjectivity of clinical decision making. However, health disparities among racial/ethnic minorities are persistent in spite of the adoption of standardized care based on evidence.

The EBP with racial and ethnic minorities is often seen as a possible cause of health and health care disparities. Three potential issues of using EBP to reduce health disparities have been identified: (1) a lack of data for EBP with ethnic/racial minority populations; (2) limited research on the generalizability of the evidence based on a European-American middle-class; and (3) sociocultural considerations in the context of EBP. Using EBP to reduce disparities in health care and health outcomes requires that nurse professionals should know how to use relevant evidence in a particular situation as well as to generate knowledge and theory which is relevant to racial/ethnic minorities. In addition, EBP implementation should be contextualized within the sociocultural environments in which patients are treated rather than solely focusing on the health problems.

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1. Introduction

According to the 2010 census data, minorities now account for approximately 37% of the United States' (U.S.) population, up from 12.5% in 1970; this figure is projected to increase to 40% by 2020 (U.S. Bureau of Census, 2011). Despite the fact that there have been advances in health science and medical technology as well as the introduction of evidence-based practice (EBP) over the past three decades, the continued racial/ethnic health and health care disparities are evident as both old and new references have shown the same patterns of health disparities (Agency for Healthcare Research and Quality, 2008; Institute of Medicine [IOM], 2001; 2002; 2010, U.S. Bureau of Census, 2011; Jemal, Siegel, Ward, Xu, & Ward, 2010; LaVeist, Pollack, Thorpe, Fesahazion, & Gaskin, 2011; Lee & Baik, 2010; Smedley, Stith, & Nelson, 2003).

EBP originated in countries with national health systems (Evidence Based Medicine Working Group [EBMWG], 1992; Guyatt et al., 1995; Sackett, 1986). However, access to health care is not universal in the U.S. and more than 19% (48.1 million of people) of those under age 65 were without any form of health insurance in 2004 and most of the uninsured were (and still are) racial/ethnic minorities (Department of Health and Human Services [DHHS], 2011; Rhoades, 2005). An individual in the U.S. who is able to pay for health services can select both the circumstances and quality of health care services, hence the patient's circumstance is not only influenced by cultural factors but also by predetermined socioeconomic factors imbedded in our health care financing system.

The National Institutes of Health (2004) has defined health disparities as diseases, disorders, and conditions that disproportionately afflict individuals who are members of racial and ethnic minority groups. The Institute of Medicine (2002) has provided empirical evidence of health and health care disparities among racial/ethnic minority groups. Cultural differences, lack of health care access, high rates of poverty, and unequal treatment by health care professionals contribute to substantial ethnic/racial health disparities. For example, the U.S. ranked 30th in the world in maternal mortality in 2000 (Tucker, Berg, Callaghan, & Hsia, 2007). One reason behind such a low ranking is the significant disparities between Black and White women; Black women consistently experience almost a fourfold greater risk of death from pregnancy complications, independent of age, parity, or education.

The racial/ethnic differences in cancer incidence and mortality are one of many areas that reflect the heterogeneity of the population and the quality of health care in the U.S. (Baquet, Mishra, Commiskey, Ellison, & DeShields, 2008; Jemal et al., 2010; Parker, Wingo, Ries, & Heath, 1998). Although overall cancer incidence rates

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appear to have stabilized over the last 10 years, incidence and mortality patterns differ across racial/ethnic groups (Tucker et al., 2007). Black men have a 25% higher incidence rate and a 43% higher death rate than White men for all cancer sites combined. White women have the highest incidence of breast cancer as well as a higher age-adjusted breast cancer rate than minority women, yet Black women have much higher mortality rates than White women (Baquet et al., 2008; Hirschman, Whitman, & Ansell, 2007). Major cancer sites and higher mortality rates that are not common in the general population, especially among Whites, are often seen in minority groups, including liver, stomach, pancreatic, and cervical cancer (American Cancer Society [ACS], 2010). Interestingly, most of these cancers (e.g., liver and cervical cancers) are caused by infection, and are vaccine preventable. Yet these cancers are not ranked highest in other populations, and hence, *Healthy People 2010* (Department of Health and Human Services, 2001) does not recognize these cancers as prioritized health disparities.

Numerous studies have documented that the quality of health care in the U.S. varies according to patients' race/ethnicity, income, education, and environment (Department of Health and Human Services, 2011; Institute of Medicine, 2001; Koh, Oppenheimer, Massin-Short, Emmons, & Geller, 2010; LaVeist et al., 2011; Smedley et al., 2003). The midcourse review of *Healthy People 2010* (Department of Health and Human Services, 2007) warned that reducing or eliminating health disparities remained a critical scientific challenge, as well as a moral and ethical dilemma for the nation. A blue ribbon panel convened by the IOM (Institute of Medicine, 2001; Smedley et al., 2003) noted in its report, *Unequal treatment: confronting racial and ethnic disparities in health care*, that racial/ethnic minorities (even when adjusted for access to health care) receive poorer quality care than White patients for many medical conditions. The IOM panel reviewed over 100 studies that assessed the quality of healthcare provided to various racial and ethnic minority groups and recommended the use of evidence based guidelines as an important means to achieve the consistency and equality of care among racial/ethnic minority populations (Nelson, 2002).

Along with this impetus in a larger health care context, the term “evidence-based practice” has been enthusiastically accepted by nursing, and thus, has become embedded in nursing education, practice, and research (American Association of College of Nursing [AACN], 2007; Ingersoll, 2000). Within the past three decades, EBP has quickly become a mantra for nurses who would have otherwise rejected nursing practices that were based on evidence drawn from individual clinical experiences, interactions, or intuition (versus scientific research). EBP is now considered as the way to do things and the way to avoid harmful interventions for all.

Despite the enthusiastic acceptance and use of EBP to promote quality of care across populations over the past three decades, the gap in health disparities has not been reduced among most racial/ethnic groups (Department of Health and Human Services, 2007; Institute of Medicine, 2002). Our efforts to reduce health disparities by means of EBP may have overlooked the conceptualization of “evidence” and its application to “evidence-based” practice for ethnically/racially diverse populations.

While EBP has been defined as the conscientious explicit, and judicious use of the current best evidence in making decisions about the care of patients (Sackett, Rosenberg, Gray, & Richardson, 1996), there are different definitions of EBP with different emphasis. However, an early definition that was based on the hierarchy of evidence has promoted randomized controlled trials (RCTs) as the most valid source of evidence (Evidence Based Medicine Working Group, 1992; Guyatt et al., 1995; Sackett, 1986; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000; Sackett et al., 1996), deemed efficacious through systemic analysis of accumulated RCTs. The problems with current EBPs focused on reducing health disparities may stem from an overemphasis on research knowledge, that does not equally emphasize the patient's values and preference and the sociocultural situation in which the care is delivered as well as the clinicians' expertise. This assertion might have unintentionally led to a depreciation and misunderstanding of the role of the sociocultural context in which EBP is implemented. Along the same line, the application of existing evidence to racial/ethnic minority populations without considering sociocultural differences from which that existing data were generated can compound the problem.

Therefore, the purpose of this article is to respond to a question, “Why does EBP not improve health and health care for racial/ethnic minorities in the US?” The issues of the application of EBP with racial/ethnic minority populations will be discussed in three areas: (1) a lack of data for EBP with ethnic/racial minority population; (2) limited research evaluation of the generalizability of the evidence based on a European-American middle-class; and (3) sociocultural considerations in the context of EBP.

2. Data disparities and EBP

The nation's minority populations are rapidly increasing and by the year 2050, projections show that ethnic minorities will comprise over 50% of the U.S. (U.S. Bureau of Census, 2011). Therefore, it is imperative to generate data on which EBP can be based for these rapidly growing subpopulations. However, available evidence to date does not reflect this multicultural transformation; neither the generation of evidence nor the application or translation of generated evidence among these rapidly growing racial/ethnic minorities is proportionate to their growth (Corbie-Smith, Moody-Ayers, & Thrasher, 2004; Lee & Baik, 2010; Department of Health and Human Services, 2001, 2011; LaRoche & Christopher, 2008).

Over the past several decades, in our nation's effort to address and bridge the gap in health disparities, *Healthy People 2010* objectives have been used as a means to inform health policy, justify allocating research funds, and design health intervention programs (Department of Health and Human Services, 2001). Reflecting upon data drawn from both *Healthy People 2000* and *Healthy People 2010* in the areas of disparities in health and health care, *Healthy People 2020* (Department of Health and Human Services, 2011) expands its goal to achieve health equity, eliminate disparities, and improve the health of all groups while focusing on determinants of health and health care at both individual and population levels.

Most of the existing data in Healthy People 2020 is referenced from national population based studies or national surveillance data, but their methodologies do not reflect the demographic characteristics of minorities. For instance, in *Healthy People 2020*, as in most other national health reports, data on Asian American Pacific Islanders (AAPIs) is not provided. The most common notations regarding AAPIs include: “data have not been analyzed (DNA),” “data have not been collected (DNC),” and “data are statistically unreliable (DSU).” This finding confirms the earlier report that only 0.2% of all federal health-related grants in the CRISP database and only 0.01% of studies found on MEDLNE identified AAPIs as the targeted study group (Ghosh, 2003). Such data generation gaps pose fundamental challenges for bridging the gap in health disparities in this particular subgroup, and consequentially, for meeting the nation's goal for all groups. First, the lack of accurate population-based data from this ethnic group masks their health needs because no data clearly attest to their unique health problems. Seconds, the lack of data offers no defined baseline of the health status and health behavior of AAPIs from which goals can be set and evaluated. Third, as a consequence, the absence of baseline data makes it almost impossible for grant funders, researchers, and practitioners to know where to target and how to reduce the gap.

Indeed, data disparities not only impact how science understands health disparities but also how to provide evidence to develop health interventions to improve health. In general, researchers have

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