INTRODUCTION

The Promise of Evidence-Based Medicine

The spectacular ascent of medical science at the dawn of the 21st century trumpets a new era in US healthcare and great possibilities for preserving human health. At the same time, it poses serious challenges for policymakers who must make crucial decisions about the safety, efficacy, and affordability of medical technologies. One of the most difficult and contentious matters confronting decision makers is the question of how to ensure the delivery of life-saving technologies to low-income and minority patient populations, whereas simultaneously controlling ever-rising healthcare costs. In theory, the increasingly popular concept of evidence-based medicine (EBM) suggests a potential tool for both cost containment and the reduction of severe racial and ethnic disparities in healthcare delivery. Drawn from systematic reviews of studies that use rigorous research methods, particularly the randomized controlled trial, the “evidence” guiding EBM protocols informs treatment decisions made by physicians, as well as policy decisions regarding the allocation of health technologies at the population level.

Operating largely out of the “average” American’s view, EBM protocols are policy devices that set the rules for who gets what medical care and on what terms. The foremost claim of some advocates of EBM is that it serves this function well by providing the best available “evidence” about therapeutic interventions, thereby enhancing the capacity of policymakers and
physicians to make sound, defensible decisions. At least in theory, the use of EBM should lead invariably to rational decisions so that patients with the same illnesses and clinical indications receive appropriate interventions regardless of race or ethnicity. Again in theory, policy decisions made within EBM frameworks should lead to evenhandedness in the allocation of therapeutic interventions at the population level. Thus, EBM offers the “implicit promise of greater fairness than previously existed (1–4).”

The National Dilemma of Racial Health Disparities

This latter promise—the assurance of greater fairness, and, by logical extension, a reduction in healthcare disparities—should not be accepted without critique. Health inequality represents one of the most persistent, ubiquitous, and troubling phenomena in the United States health system. Evidence of racial disparities in health status long predates the Civil Rights era (5), with systematic studies that document these disparities appearing in the literature at least as early as 1899 (6). Clayton and Byrd have richly documented a continuous pattern of systemic racial inequality in healthcare dating back to at least the 17th century and persisting, significantly unabated, into the present millennium (7,8).

Over the past two decades, at least 600 journal articles and eight major reviews—most notably the 2002 report by the Institute of Medicine (IOM), Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare—have verified deep racial inequities in healthcare (9,10). Systematically reviewing over 100 studies conducted between 1992 and 2002, the landmark IOM report found that racial gaps persist in the delivery of evidence-based interventions even when researchers take into account such factors as insurance coverage, disease severity, and expression of symptoms. These disparities span an alarming array of major diseases, including heart disease, diabetes, end-stage renal disease, and AIDS. Racial disparities manifest across numerous diagnostic and therapeutic procedures, including cardiac procedures, renal transplantation, and the delivery of pharmaceuticals. Most significantly, it is consistently documented that racial inequities in healthcare delivery result in higher morbidity and mortality for minority populations.

Furthermore, there is strong evidence that in recent years the nation has made only the slightest progress in correcting this problem. A recent issue of the New England Journal Medicine reported on three studies examining national progress over the past decade in closing the racial gap in healthcare (11–13). Accounting for key variables such as age, sex, socioeconomic status, and health plan, the studies analyzed healthcare delivery patterns for both high-cost and low-cost evidence-based medical interventions. In one study, in an