To the Editor:
I read with interest the research letter by Luu et al.1 The authors demonstrate similar rates of major adverse cardiovascular events and cardiovascular mortality between non-Hispanic Black and non-Black women seeking treatment at academic medical centres in the U.S. The accompanying editorial raises important methodologic limitations of the study, including small sample size and omission of relevant covariates, including cholesterol levels and lifestyle factors.2

The authors close their paper with a provocative conclusion, that “Black women with [coronary artery disease] treated in university/academic centres experience less racial and ethnic discrimination and receive appropriate guideline-directed therapy,” as well as a firm policy proposal, that “Physician and community education campaigns should be instituted to mitigate structural racism in [cardiovascular disease] in community health care settings.”

A conclusion as strong as this requires further elaboration, which the authors do not provide and which their data do not support. To be sure, university/academic medical centres in the U.S.—the sort that were included in the Women’s Ischemia Syndrome Evaluation (WISE) study—tend to be located in urban areas and tend to serve medically complex and socially disadvantaged populations, as consistent with their unique social mission.3 But the authors are mistaken in implying that the absence of an observed racial disparity in cardiovascular outcomes at academic centres indicates that these centres are doing something right—and, by extension, that centres in the community are performing suboptimally.

The WISE study did not include community health care centres, but they are a heterogeneous group. They, too, frequently perform a crucial role in the U.S., treating historically underserved rural patients.3 This role is especially important in an era of increasing financial pressures and widespread rural hospital closures. Singling out community hospitals, then, as somehow less inclusive or more discriminatory seems unwarranted—especially in light of recent work demonstrating that some of the largest academic centres in the U.S. continue to be highly segregated by race, ethnicity, and payer.4

In the U.S., poverty and inequality persist both within and across racial groupings. Rates of un- and underinsurance remain unacceptably high. Rather than focusing on developing institutions aimed at serving specific racial populations, as the editorial accompanying the paper by Luu suggests, achieving equity in cardiovascular health in the U.S. will require something much more difficult, namely, the creation of broad-based universal social programs that can transcend these divisions.

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References