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Quality of Care in Profit vs Not-For-Profit Dialysis Centers—Reply

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Among those raising objections to affirmative action, Dr Miller introduces the “quota” word. This hypercharged word is often used to polarize the debate about affirmative action, which in fact does not entail decision making designed to achieve a predetermined numerical target, ie, a quota. Indeed, the use of quotas in higher education admissions was deemed unconstitutional in *Bakke*<sup>1</sup> and was correspondingly abandoned decades ago. Dr Goldberg takes me to task for using “diversity” as a framework for advocating greater participation in medicine of underrepresented racial and ethnic minorities, noting that many other kinds of diversity might have salutary effects on medical education and practice. That view notwithstanding, it is race- (and ethnic)-conscious decision making that is currently under assault and in need of defense.

Dr Heider and Dr Ramseyer contend that the use of race-conscious decision making in medical school admissions is tantamount to “racial discrimination.” They argue that affirmative action denies applicants “equal protection (which) means that all students of equal ability have an equal chance of admission.” Unfortunately, their view fails to appreciate both the fundamental purpose of medical schools and the complex mix of attributes required of a student body to fulfill that purpose.

Medical schools are charged with a vital social mission—to ensure that the future physician workforce is optimally prepared to address the health care needs of the public, all of the public. They are not charged simply with rewarding individuals who have amassed the best academic credentials, as if that were equivalent to “ability.” To have the ability to serve the needs of an increasingly diverse public, the cohort of students chosen for admission must be qualified not only to meet all of the rigorous academic hurdles of medical school, but also to provide access to quality health care for all.

When medical schools decide which applicants to admit, they take a host of factors into account, eg, leadership, capacity for hard work, willingness to serve others, and empathy. Grade point averages and MCAT scores are also among those factors and are used to gauge an applicant’s preparedness for the curricular demands of the MD degree. “Race-blind” admissions procedures would require all applicants to compete for the limited places in medical school on the basis of these “objective” measures. The regrettable fact is that very few underrepresented minority applicants, for a variety of reasons, have GPAs and MCAT scores comparable to the majority of other applicants. Affirmative actions are required to identify those students who, despite this disadvantage, have every indication of success in medical school and, more importantly, as physicians and scientists. That some 90% of underrepresented minority students clear all the hurdles and graduate is testimony to the ability of admissions committees to use affirmative action tools to ensure that “all students of equal ability have an equal chance of admission.” The inability to take race and ethnicity into account would reduce the fraction of underrepresented minority matriculants from the current level of 11% (already less than half their percentage in the general population) to 3%, a level reminiscent of the

frankly discriminatory days before the civil rights movement of the 1960s and 1970s.

Less than half of all applicants to US medical schools gain admission and matriculate. Hence, to argue that a rejected candidate has been discriminated against because of his or her race is preposterous. By the same token, to argue that fully qualified applicants from disadvantaged backgrounds should be rejected in favor of still more applicants from advantaged backgrounds is to abdicate our profession’s solemn obligation “to (1) provide a quality education for all students; (2) supply a balanced cohort of practitioners, investigators and health care managers for an increasingly diverse population; and, not least, (3) help fulfill our country’s ideals of fairness, justice, and equity.”<sup>2</sup>

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1. *Regents of the University of California v Bakke*, 438 US 265 (1978).
2. Cohen JJ. The consequences of premature abandonment of affirmative action in medical school admissions. *JAMA*. 2003;289:1143-1149.

### Quality of Care in Profit vs Not-For-Profit Dialysis Centers

**To the Editor:** In their meta-analysis, Dr Devereaux and colleagues<sup>1</sup> concluded that hemodialysis care in private not-for-profit centers was associated with a lower risk of mortality compared with care in private for-profit centers.

From more than 7045 citations, the authors selected only 8 to use in their analyses. Of these, 1 involved patients in a single state from 1973 to 1981<sup>2</sup>; 3 were from dissertations that have never been peer reviewed or published<sup>3-5</sup>; and 1 was a letter to the editor.<sup>6</sup> The article by Garg et al<sup>7</sup> was previously critiqued.<sup>8,9</sup> The study of McClellan et al<sup>10</sup> showed no differences in mortality between for-profit and not-for-profit dialysis facilities, and the study by Irvin<sup>11</sup> was an analysis of US Renal Data System (USRDS) data that found only a small (1%-2%) higher probability of dying in a for-profit dialysis unit.

The authors excluded 12 studies. Several of these analyzed USRDS data from the same time period as the studies cited by Devereaux et al, yet found smaller differences in mortality between for-profit and not-for-profit facilities. Some of the authors of the excluded studies have examined the more recent Centers for Medicare and Medicaid Services (CMS) database<sup>12</sup> and very recent data from the Dialysis Outcomes and Practice Patterns Study (DOPPS)<sup>13</sup> and found no differences in mortality between for-profit and not-for-profit dialysis facilities.

Devereaux et al made no distinction in the type of for-profit dialysis facilities, ie, whether affiliated with a large chain, a single owner, or a small chain. A recent abstract, however, reported that major chains had superior outcomes.<sup>14</sup>

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**Financial Disclosure:** Dr Bosch is an employee of Gambro AB, a for-profit company that provides dialysis. Dr Hakim is an employee of Renal Care Group Inc, a for-profit company that provides dialysis. Dr Lazarus is an employee of Fresenius Medical Care NA, a for-profit company that provides dialysis. Dr McAllister is an employee of DaVita Inc, a for-profit company that provides dialysis. All authors are stockholders in their respective companies.

1. Devereaux PJ, Schönemann HJ, Ravindran N, et al. Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: a systematic review and meta-analysis. *JAMA*. 2002;288:2449-2457.
2. Plough AL, Salem SR, Shwartz M, Weller JM, Ferguson CW. Case mix in end-stage renal disease: differences between patients in hospital-based and freestanding treatment facilities. *N Engl J Med*. 1984;310:1432-1436.
3. Farley DO. *Effects of Competition on Dialysis Facility Service Levels and Patient Selection* [dissertation]. Santa Monica, Calif: RAND; 1993.
4. Irvin RA. Ownership and mortality in the dialysis industry: multivariate regression analysis. In: Irvin RA. *Quality of Care, Asymmetric Information, and Patient Outcomes in US For-Profit and Not-For-Profit Renal Dialysis Facilities* [dissertation]. St Louis, Mo: Washington University; 1988:55-80.
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13. McCullough KP, Held PJ, Gillespie BW, Young EW, Bragg JL, Port FK. Survival among dialysis patients in for-profit and not-for-profit hemodialysis (HD) facilities [abstract]. *ASAIO J*. 2001;47:158.
14. Brier ME, Aronoff GR. Effect of the ownership of dialysis facilities on adequacy of dialysis and the treatment of anemia: comparison between for-profit and not-for-profit hemodialysis facilities from the Renal Network Data System (TRNDS). Presented at: American Society of Nephrology 35th Annual Meeting; November 1-4, 2002; Philadelphia, Pa. Abstract SU-P0723.

**To the Editor:** I have a number of concerns about the meta-analysis by Dr Devereaux and colleagues.<sup>1</sup> First, the authors excluded a number of articles from their synthesis of findings that address the private vs public comparison. The majority of excluded articles found no differences in mortality between private for-profit and not-for-profit facilities when public facilities are included. Furthermore, 3 of the 8 studies were doctoral dissertations. In fact, 1 dissertation appears to be included as 2 separate studies. Another study is an article by the author of this dissertation which appears based on the dissertation data.

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In total, there appear to be only 6 independent studies, one of which was a letter to the editor.

A second problem involves the apparent absence for controls for social factors that influence mortality among patients requiring dialysis. For example, Avorn et al<sup>2</sup> reported that failure to consult with a nephrologist at least 90 days prior to the initiation of dialysis was associated with increased mortality during the first year of dialysis. This practice is obviously outside the purview of the dialysis center. Bakewell et al<sup>3</sup> found that ethnicity may influence survival. Controlling for race is thus insufficient to account for all related confounding factors. Allen et al<sup>4</sup> reported a link between nutrition and survival. Finally, Delano et al<sup>5</sup> have described the challenges of providing dialysis treatment to individuals living in poverty. These studies represent only a portion of the available literature identifying predictors of survival in dialysis. Other factors such as the availability of transplants, suitability for transplant, and substance-related comorbidities all influence mortality in renal dialysis. The value of random assignment to treatment groups is that it allows us to assume equivalence between groups for these potential confounding factors. Observational studies must control for the known predictors of outcomes that are outside the focus of the intervention.

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1. Devereaux PJ, Schönemann HJ, Ravindran N, et al. Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: a systematic review and meta-analysis. *JAMA*. 2002;288:2449-2457.
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**To the Editor:** Dr Devereaux and colleagues<sup>1</sup> acknowledged the ongoing debate in Canada about the optimal mix of private and public funding of health care expenses. However, we disagree with their characterization of this debate as between private for-profit and private not-for-profit entities. In fact, the majority of hospital-based care in Canada, including nearly all dialysis, occurs in public not-for-profit institutions. While nominally independent, Canadian hospitals generally receive almost all their funding from provincial governments and are administered by boards that must answer to them.<sup>2</sup> In our opinion these hospitals function as public institutions.

The comparison of private not-for-profit and private for-profit dialysis clinics is thus of limited relevance to countries such as Canada, where dialysis is mainly provided by public hospitals. While we do not advocate a shift to US-style private for-profit dialysis, we think it is unfortunate that the conclu-

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