In *JAMA Network Open*, Jenkins et al. report alarming racial disparities in in-hospital mortality among children presenting to the emergency department (ED) for acute medical illnesses. In a sample of 633,536 children treated at 1 of 586 EDs across 11 states between 2012 and 2017, Black children with acute medical illness had higher adjusted odds of death compared with the overall sample mean. These findings add to an upsetting body of literature demonstrating that, throughout health care, Black children have disproportionately high rates of death. Black children are more likely than children of other races to die of sepsis, sudden cardiac arrest, congenital heart disease, and cancer, as well as after routine outpatient surgery. Although long-standing structural racism has led to Black children having elevated disease burden and risk of health-related social need, this does not sufficiently explain the inequitably high mortality rate. Jenkins et al. present findings similar to others: racial inequities in child mortality persist when accounting for sociodemographic factors, disease complexity, and illness acuity. With the critical recognition that race and ethnicity are social constructs and not biologic entities, this meaningfully implicates inequitable care delivery as one driver of disparate childhood death.

There are marked differences in pediatric emergency care based on a child’s race and ethnicity. When presenting with similar conditions that ultimately require hospitalization, Black children are initially triaged at lower acuity levels than White children. Black children are less likely to receive antibiotics, intravenous hydration, and adequate pain medication. Additionally, they are less likely to be recognized as having severe infections, including appendicitis and sepsis. Such differences in treatment likely represent only a subset of the inequitable care decisions and processes that lead to differential rates of child death.

Despite this, Jenkins et al. found no disparity in mortality among Black and White children after traumatic injuries. However, this apparently supposedly equitable outcome occurred despite the fact that a greater proportion of Black children than White children have timely access to verified pediatric trauma centers, a difference that should portend better outcomes for Black children with injuries. Given the widespread use of advanced trauma life support in the management of traumatic injuries across ED settings, the authors raise the hypothesis that protocolized care, as put forth in advanced trauma life support, is a mechanism for reducing disparities. This hypothesis, which has been raised in the context of other care disparities that appear mitigated in the presence of clinical guidelines, is promising and should be formally tested in future research.

Jenkins et al. take an important step forward beyond the documentation of disparities to identify a potential modifier of inequities in childhood mortality. By analyzing linked patient- and hospital-level data, they demonstrate that inequities in child mortality are lower in hospitals with high pediatric readiness. They further estimate that the effect of pediatric readiness contributed to a 3-fold lower rate of child mortality inequity in EDs with the highest readiness compared with those with the lowest. Although the cross-sectional study design prevents attribution of causality, Jenkins et al. provide a compelling argument for the National Pediatric Readiness Project to systematically incorporate health equity into efforts to increase pediatric readiness in hospitals across the US.

ED pediatric readiness, as assessed through the weighted scoring of responses to an online questionnaire completed by ED nurse managers, is not a direct proxy for the quality of pediatric care. Instead, this serves as a marker of the resources available to health care professionals when treating...
children at these hospitals. High ED pediatric readiness has been found to be associated with important patient-centered outcomes, including fewer transfers from small rural hospitals and improved short- and long-term survival. Resources provided through the National Pediatric Readiness Project are essential to improving child health, particularly given the infrequency of critical pediatric procedures and the decreasing availability of pediatric inpatient care. As noted by the authors, to best apply the findings of this study, efforts to center equity in readiness should seek to understand which components of readiness most contribute to equity. However, one important caveat is that the assessed components of ED pediatric readiness have been intentionally selected to represent factors that are modifiable. The findings here remained significant in sensitivity analyses that controlled for select hospital-level factors, yet given the impact of structural racism and residential segregation on inequities in access to high-quality hospital care, the contributing role of systems-level factors must be further assessed.

As we continue our search for solutions to reduce health disparities, there is a critical need for health equity researchers to use high-quality statistical methods. Jenkins et al have thoughtfully conducted their analyses such that the reference group for race and ethnicity is the grand mean. This is in contrast to traditional approaches to presenting data in comparison with 1 subgroup (often non-Hispanic White) as the reference, which propagates the inaccurate assumption that 1 group represents the normative standard. Comparing results with the grand mean typically does not change the significance of findings. Instead, this subtle but important shift embraces inclusivity by allowing us to consider each subgroup in relation to the whole, rather than establishing 1 subgroup as the norm and all others as exceptions.

This study highlights the complexity of race and ethnicity data collection and categorization in several ways. First, to ensure accurate representation of race and ethnicity, these data should be self-identified. Jenkins et al take a necessary step in noting this limitation when describing their data set. Second, in this study, race and ethnicity were considered a single variable, an approach that appropriately acknowledges that both are social constructs that represent the impact of experienced racism. For the purposes of federal reporting, however, race and ethnicity are considered separate variables, although the federal government has proposed to change this practice. Until such changes take place, health equity researchers should continue to collapse these data into a single variable but must maintain careful standards when doing so. Hispanic children, who may not identify with a distinct race category, may be more likely to have missing race information. As such, if exclusions based on missing race data are done before consideration of ethnicity, there is a risk of systematically excluding Hispanic children and masking disparities. In this analysis, there was a large number of exclusions for missing race and ethnicity overall, a limitation that is not unique to this study. Although the authors have been intentional in accounting for this in their analytic approach, the missingness of race and ethnicity data remains problematic across health equity research. Finally, more than 25% of the sample in this study falls into the category of other race or ethnicity. While smaller groups are often condensed into larger ones for analysis, this risks missing important differences within the aggregated groups and erasing or invalidating unique populations.

The work by Jenkins et al raises meaningful hypotheses about enhancing pediatric readiness as a strategy to reduce health disparities. Most notably, however, is the stark reminder of how children and families remain impacted by the far-reaching effects of structural racism and individual biases. As we continue our search for effective interventions that promote health equity, such research provides a powerful impetus for the ongoing need for high-quality research to inform our efforts.

ARTICLE INFORMATION
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