
PURPOSE: Our goal is to describe the effect of race and ethnicity on stroke epidemiology, personal beliefs, access to care, response to treatment, and participation in clinical research. In addition, we seek to determine the state of knowledge on the main factors that may explain disparities in stroke care, with the goal of identifying gaps in knowledge to guide future research. The intended audience includes physicians, nurses, other healthcare professionals, and policy makers.

METHODS: Members of the writing group were appointed by the American Heart Association Stroke Council Scientific Statement Oversight Committee and represent different areas of expertise in relation to racial-ethnic disparities in stroke care. The writing group reviewed the relevant literature, with an emphasis on reports published since 1972. The statement was approved by the writing group; the statement underwent peer review, then was approved by the American Heart Association Science Advisory and Coordinating Committee.
RESULTS: There are limitations in the definitions of racial and ethnic categories currently in use. For the purpose of this statement, we used the racial categories defined by the US federal government: white, black or African American, Asian, American Indian/Alaskan Native, and Native Hawaiian/other Pacific Islander. There are 2 ethnic categories: people of Hispanic/Latino origin or not of Hispanic/Latino origin. There are differences in the distribution of the burden of risk factors, stroke incidence and prevalence, and stroke mortality among different racial and ethnic groups. In addition, there are disparities in stroke care between minority groups compared with whites. These disparities include lack of awareness of stroke symptoms and signs and lack of knowledge about the need for urgent treatment and the causal role of risk factors. There are also differences in attitudes, beliefs, and compliance among minorities compared with whites. Differences in socioeconomic status and insurance coverage, mistrust of the healthcare system, the relatively limited number of providers who are members of minority groups, and system limitations may contribute to disparities in access to or quality of care, which in turn might result in different rates of stroke morbidity and mortality. Cultural and language barriers probably also contribute to some of these disparities. Minorities use emergency medical services systems less, are often delayed in arriving at the emergency department, have longer waiting times in the emergency department, and are less likely to receive thrombolysis for acute ischemic stroke. Although unmeasured factors may play a role in these delays, the presence of bias in the delivery of care cannot be excluded. Minorities have equal access to rehabilitation services, although they experience longer stays and have poorer functional status than whites. Minorities are inadequately treated with both primary and secondary stroke prevention strategies compared with whites. Sparse data exist on racial-ethnic disparities in access to surgical care after intracerebral hemorrhage and subarachnoid hemorrhage. Participation of minorities in clinical research is limited. Barriers to participation in clinical research include beliefs, lack of trust, and limited awareness. Race is a contentious topic in biomedical research because race is not proven to be a surrogate for genetic constitution.

CONCLUSIONS: There are limitations in the current definitions of race and ethnicity. Nevertheless, racial and ethnic disparities in stroke exist and include differences in the biological determinants of disease and disparities throughout the continuum of care, including
access to and quality of care. Access to and participation in research is also limited among minority groups. Acknowledging the presence of disparities and understanding the factors that contribute to them are necessary first steps. More research is required to understand these differences and find solutions.