symptoms might indicate a serious illness; and were surprised at how long a RTI could persist for and how frequently a child could get a RTI, particularly in the first years of life. This was true for parents from all socio-economic backgrounds and with different levels of education. When consulting, parents were often seeking a medical assessment and reassurance. However, parents felt that clinicians were often dismissive and had not properly evaluated the child, often leading to re-consultations. In addition, clinician explanations of diagnosis and treatment recommendations were not well understood by parents, and they remained unclear about how to manage an RTI and when to consult.

Conclusion Parents' poor knowledge and un-realistic expectations in relation to RTIs in children contribute to high rates of consultation. Despite awareness of parental perspectives, there remains a problem with parent-HP communication in relation to key information needed by parents to manage child's illness confidently and know when to consult in future.

OP66 A PROFILE OF UNDIAGNOSED DIABETICS IN THE COMMUNITY: RESULTS FROM THE BOSTON AREA COMMUNITY HEALTH (BACH) PRE-DIABETES SURVEY

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Background Research suggests almost 30% of the United States population has undiagnosed diabetes and that diabetics typically have the disease for 4 to 7 years before eventual diagnosis. Delay in initial diagnosis results in greater diabetes-related complications, poorer patient outcomes, and reduced quality of life. Most diabetes research is necessarily confined to diagnosed diabetes. Our objective was to identify risk factors for remaining undiagnosed.

Methods The Boston Area Community Health (BACH) Pre-Diabetes study is an ongoing community-based random-sample cohort study that has enrolled 2,974 participants to date. Participants were asked to fast for 8 hours prior to their interview. Fasting glucose (FG) and glycated hemoglobin (HbA1c) were collected during in-home interviews. Undiagnosed diabetes was defined as FG >125 mg/dL or HbA1c ≥ 6.5%. Risk factors were organized into four logical groupings: 1) socio-demographics, 2) lifestyle/behavioral, 3) utilization/access to healthcare, and 4) health status/comorbidities. Logistic regression was used to estimate the odds ratio (OR) for diagnosed vs. undiagnosed diabetes.

Results The prevalence of diabetes in the BACH study was 27.8% (n=827). 21.2% of diabetes cases were undiagnosed. The data indicate that healthcare utilization and the presence of co-morbid conditions had a large impact on diabetes diagnosis. Participants who visited a health care provider 5 or more times in the past year were 90% more likely to be diagnosed (OR=1.9, p<0.001) than participants who had 5 or fewer visits. Participants with a history of high cholesterol were more than twice as likely to be diagnosed (OR=2.7, p<0.001). High blood pressure or a history of heart disease also increased the likelihood a participant was diagnosed. Participants with a documented family history of diabetes were more likely to be diagnosed (OR=2.9, p<0.001). Finally, English-speaking participants were more than twice as likely to be diagnosed (OR=2.6, p=0.01) than their Spanish-speaking counterparts.

Conclusion Undiagnosed diabetes is highly prevalent problem in the United States that leads to poorer patient outcomes and significant health-care costs. These results indicate that access to care, health care utilization and the presence of co-morbid conditions have an important impact on diabetes diagnosis. Individuals who do not have the traditional risk factors for diabetes (i.e. family history) have a greater risk of remaining undiagnosed. These findings suggest that improving access to care in the United States may greatly increase the likelihood of diagnosing previously undiagnosed diabetes.

OP67 DO DOCTORS CONTRIBUTE TO THE SOCIAL PATTERNING OF DISEASE? CONTRASTING FINDINGS FROM AN EPIDEMIOLOGIC SURVEY AND A DECISION MAKING EXPERIMENT

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Background That type 2 diabetes mellitus (T2DM) varies significantly by race and ethnicity is a widely accepted fact. It is often invoked as a base rate (*a priori* probability) during the process of clinical reasoning. Epidemiological studies repeatedly show undiagnosed T2DM varies more by socioeconomic status (SES), than by race/ethnicity. This study seeks to understand the discrepancy between the true prevalence of undiagnosed T2DM by SES and its continually reported prevalence by race/ethnicity.

Methods Data from two different but complementary studies are employed: a) a large Boston Area Community Health (BACH) survey; and b) a factorial experiment conducted with primary care doctors to examine variations in clinical decision making. The BACH epidemiologic survey (n=5502) employed a stratified, multi-stage cluster sample design and used multivariable techniques including logistic regression. The factorial experiment concerning decision making employed clinically authentic videotaped scenarios presented to primary care doctors (n=192), and used ANCOVA analyses.

Results Results from the epidemiologic survey show that both undiagnosed signs and symptoms and diagnosed T2DM vary similarly by socio-economic status (SES). This finding is independently corroborated by National Health and Nutrition Examination Survey (NHANES) data for diagnosed T2DM. Complementary data from the clinical decision making experiment show the diagnosis of T2DM varies significantly by a patients' race/ethnicity, controlling for SES, age and gender in the design. While undiagnosed signs and symptoms of T2DM in the community vary significantly by SES, rather than race/ethnicity, following diagnosis by primary care doctors they vary more by race/ethnicity, rather than by SES.

Conclusion Race/ethnicity and SES in the US are almost totally confounded, such that measuring one is essentially also measuring the other. Consequently, doctors generally get the social patterning of T2DM right, but for entirely the wrong reason. Continued patterning of T2DM by race/ethnicity motivates the search for genetic and biophysiologic explanations and distracts attention from the more important and potentially modifiable contribution of SES circumstances to the prevalence of T2DM.

OP68 THE CONTRIBUTION OF DOCTORS' DECISIONS TO HEALTHCARE INEQUALITIES: TOWARDS FOURTH GENERATION STUDIES

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Background Healthcare variations are a worrisome and well-documented problem. Such variations occur at different levels: between health care systems, geographic areas, organizational settings, patients, and doctors. Research is increasingly focused on the contribution of doctors' decision making to the generation or amplification of healthcare disparities. Clinical decision making studies continue to evolve through generations of work that focus on different types of influence: **First generation** studies identified patient-level attributes (e.g., gender, age, race/ethnicity, SES, health insurance status); **Second generation** studies on variations associated with physician characteristics (e.g., age, gender and education, specialty and type of remuneration); **Third generation** studies on health system and