Racially Concordant Care

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Accreditation Council for Graduate Medical Education
Care provided by a physician who shares the racial identity of the patient

<table>
<thead>
<tr>
<th>Why do individuals seek out physicians of their same race/ethnicity/religion?</th>
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</thead>
<tbody>
<tr>
<td>Comfort/familiarity</td>
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<tr>
<td>Language concordance/communication</td>
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<tr>
<td>Safety - psychological, physical</td>
</tr>
<tr>
<td>Trust, respect</td>
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<tr>
<td>Shared world-view</td>
</tr>
<tr>
<td>Proximal location</td>
</tr>
</tbody>
</table>

Why do physicians disproportionately care for patients of their same race/ethnicity/religion?

- **Race-conscious professionalism**
  - Sense of doing a societal good; Recognition of unique role; job satisfaction
  - Identifies with the population served
  - Sense of belongingness

- **Exclusion from markets**
  - Discrimination/Racism
  - Elitism
Black mothers are mistreated in our health systems

Across race and ethnicity, including Asian and Pacific Islander mothers, Latina mothers, Black mothers, and white mothers, women reported experiencing discrimination during childbirth. ¹

1 in 10 women reported being spoken to disrespectfully by hospital personnel.

10% reported “rough handling” by hospital personnel and being ignored after expressing fears and/or concerns.

Black women were more likely to report unfair treatment and discrimination within the health care system than white women and Latina women.

Patients see themselves in their physicians

Physician-patient relationship is strengthened when patients see themselves as similar to their physicians in personal beliefs, values, and communication.

Perceived personal similarity is associated with higher ratings of trust, satisfaction, and intention to adhere. Race concordance is the primary predictor of perceived ethnic similarity.

Benefits of racially concordant care

Addresses the unfortunate reality of how we trust in American society

Intention to adhere to medical advice is heightened

Patient satisfaction is better among historically marginalized individuals who receive racially concordant care

Improved clinical outcomes in some categories has been shown

Improves access to care for individuals who would rather forego care than to receive it in an environment that dehumanizes them, discriminates against them and fails to communicate effectively with them
Vaccine hesitancy among minoritized individuals

Everyday racism can be tackled in the present.

Framing the conversation about distrust in Covid vaccines in terms of everyday racism rather than historical atrocities may increase underserved communities’ willingness to be vaccinated.

Hazard of depending on racially concordant care to eliminate health disparities

Racial and ethnic health inequities occur because of a number of factors, more social than medical.

The social determinants of health contribute to excess morbidity and mortality that does not have a solely medical solution: Lack of access to healthy foods and food practices; inundation with ultraprocessed foods; community violence; lack of access to greenspace for play and exercise; environmental conditions; housing insecurity; poverty/wealth gap; allostatic load; adverse childhood events; inadequate transportation; neighborhood disinvestment; overpolicing; residential segregation; and, structural racism\(^1\)

The political determinants of health recognize how inequitable policies, politics, regulations and laws have impaired access to care and contribute to health inequalities\(^2\)


We have not graduated enough Black, Latinx and Indigenous physicians over the past 40 years to satisfy the demand for concordant care.

All physicians must embrace cultural humility to improve the care they give to patients from historically marginalized groups.
Workforce Diversity matters to the elimination of health disparities

• Eliminating health care disparities is consistent with the mission of the ACGME to improve health care and population health by assessing and enhancing the quality of resident physicians' education through advancements in accreditation and education

• ACGME envisions a health care system where the quadruple aim has been realized, aspiring to advance a transformed system of GME with global reach that is immersed in evidence-based, data-driven, clinical learning and care environments defined by excellence in clinical care, safety, cost effectiveness, professionalism, and diversity and inclusion

• Educating physicians who are more likely to serve underserved patients and locate in minority communities increases health care access and improves trust, communication and outcomes for those most at risk for health disparities

Adopted by ACGME Board of Directors September 2020
Inverse association between where physicians practice and where disease burden is greatest

- Life expectancy differs greatly based on zip code
- Geographic co-location of physicians and disease may positively affect health outcomes
- Physician distribution is not homogeneous nor related to disease burden
Inverse association between where physicians practice & where disease burden is greatest, cont.

Life expectancy differs greatly based on zip code.

Geographic co-location of physicians and disease may positively affect health outcomes.

Physician distribution is not homogeneous nor related to disease burden.

NYT  5 Sept 2020
Where you live matters

Odds of being a PCP shortage area were 67 percent higher for majority African American zip codes

As the degree of segregation increased, the odds of being a PCP shortage area increased for majority African American zip codes

Minority dentists in non-marginalized communities still see a disproportionate number of racially concordant patients

Racially concordant patients from the three historically marginalized groups accounted for 54.1% of URM minority dentists’ patient population on average.

URM dentists typically located in counties where underrepresented minority populations make up a large share of the overall population.

Racial disparities in orthopedic care

Racial disparities in access to care exist in Medicare inpatients several cardiovascular, cancer and orthopedic procedures.

From 2012-2018, Black patients received 67,000 fewer orthopedic procedures than if the care had been equitably distributed.

In this same period, high-quality facilities performed 38,000 fewer orthopedic procedures for Black patients.

For the nearly 2 million Medicare patients who received knee replacements, all non-white groups were less likely to be treated at a High Performing hospital than white patients when compared to the overall breakdown of who is getting these surgeries at all.
2019 MSQ Results: Do you plan to practice primarily in an underserved community?

### 2020 GQ Results: Do you plan to practice primarily in an underserved community?

<table>
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<tr>
<th>Category</th>
<th>Yes</th>
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<td>17.3</td>
<td>65.4</td>
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<td>Black or African American</td>
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<td>American Indian or Alaska Native</td>
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<td>3.7</td>
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<table>
<thead>
<tr>
<th>Patient Characteristic</th>
<th>No. (%)</th>
<th>Millions of Patients With a White Physician</th>
<th>Millions of Patients With a Black Physician</th>
<th>Unadjusted Odds Ratio (95% CI)&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Millions of Patients With a Hispanic Physician, No. (%)</th>
<th>Unadjusted Odds Ratio (95% CI)&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Millions of Patients With an Asian Physician, No. (%)</th>
<th>Unadjusted Odds Ratio (95% CI)&lt;sup&gt;c&lt;/sup&gt;</th>
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<tr>
<td>All patients</td>
<td>62.2 (100.0)</td>
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<td>Non-Hispanic whites</td>
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<td>Minorities</td>
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<td>2.2 (65.3)</td>
<td>12.30 (8.30-18.00)</td>
<td>3.5 (58.5)</td>
<td>8.20 (5.98-11.23)</td>
<td>4.6 (46.3)</td>
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<td>Black, non-Hispanic</td>
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<td>1.9 (63.9)</td>
<td>23.24 (16.28-33.17)</td>
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<td>Hispanic</td>
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<td>0.96 (0.49-1.88)</td>
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<td>19.04 (13.47-26.93)</td>
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<td>Asian</td>
<td>0.9 (1.7)</td>
<td>0.1 (5.1)</td>
<td>3.06 (1.15-8.17)</td>
<td>0.3 (9.0)</td>
<td>5.63 (2.67-11.86)</td>
<td>2.3 (31.2)</td>
<td>25.73 (16.92-39.13)</td>
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<td>Other</td>
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<td>4.60 (1.78-11.94)</td>
<td>0.02 (1.1)</td>
<td>0.61 (0.17-2.15)</td>
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<td>2.25 (1.19-4.25)</td>
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<td>Income</td>
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<td>High/middle</td>
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<td>Low</td>
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<td>1.2 (35.5)</td>
<td>2.03 (1.46-2.75)</td>
<td>2.1 (34.5)</td>
<td>1.92 (1.44-2.55)</td>
<td>2.8 (29.1)</td>
<td>1.49 (1.23-1.81)</td>
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<td>Medicaid</td>
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<td></td>
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<tr>
<td>None</td>
<td>54.8 (93.2)</td>
<td>2.5 (78.4)</td>
<td>4.4 (81.8)</td>
<td>7.9 (85.2)</td>
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<tr>
<td>Medicaid</td>
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<td>0.7 (21.6)</td>
<td>3.75 (2.72-5.18)</td>
<td>1.0 (18.2)</td>
<td>3.04 (2.29-4.04)</td>
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<td>Any health insurance</td>
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<td>3.1 (95.2)</td>
<td>5.4 (90.1)</td>
<td>9.3 (94.0)</td>
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<tr>
<td>Uninsured</td>
<td>3.5 (5.7)</td>
<td>0.1 (4.8)</td>
<td>0.83 (0.49-1.41)</td>
<td>0.6 (9.9)</td>
<td>1.83 (1.30-2.57)</td>
<td>0.6 (6.0)</td>
<td>1.07 (0.78-1.47)</td>
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<td>English home language</td>
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<td>3.2 (96.8)</td>
<td>3.9 (66.7)</td>
<td>7.9 (80.4)</td>
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<td>Non-English home language</td>
<td>1.7 (2.7)</td>
<td>0.1 (3.2)</td>
<td>1.18 (0.51-2.69)</td>
<td>2.1 (33.4)</td>
<td>17.83 (12.80-24.82)</td>
<td>1.9 (19.6)</td>
<td>8.69 (6.19-12.19)</td>
<td></td>
</tr>
</tbody>
</table>

* Odds of patients in a demographic group reporting a black physician relative to non-Hispanic white patients reporting a black physician.

* Odds of patients in a demographic group reporting a Hispanic physician relative to non-Hispanic white patients reporting a Hispanic physician.

* Odds of patients in a demographic group reporting an Asian physician relative to non-Hispanic white patients reporting an Asian physician.
Primary care physicians who treat Blacks and Whites

Cross-sectional analysis of a nationally representative sample of 150,391 visits by black and white Medicare beneficiaries to 87,893 physicians

Most visits by black patients were with a small group of physicians (80% of visits were accounted for by 22% of physicians) whereas these same physicians (19,492) only saw 22% of white patients; 68,311 physicians saw 78% of white patients, but only 20% of black patients.

Physicians treating black patients report greater difficulties in obtaining access for their patients to subspecialists, diagnostic imaging, and nonemergency hospital admission.

A black physician was 39.9 times more likely to see a black patient than was a white physician.

Increasing racial/ethnic diversity in the physician workforce acknowledges racially concordant care is an important model

Isn’t forcing people to work where they don’t want to work
Isn’t limiting patient access to the best physicians
Isn’t forcing patients to only see doctors of their own race/ethnicity

Proximity is an important factor, but not the only factor
Physicians’ willingness to work in disadvantaged communities and to accept Medicare/Medicaid
Patient choice plays a role
Do Asian and White physicians choose not to work in historically marginalized communities?

Are historically marginalized physicians welcomed to practice in predominantly White or affluent communities?

Choice, exclusion or market?

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Does Diversity Matter for Health?

Black subjects were likely to talk with a black doctor about more of their health problems.

Black doctors were more likely to write additional notes about the subjects.

CV disease impact was significant, leading to a projected 19% reduction in the black-white male gap in cardiovascular morbidity and 9% in mortality.

Diabetes, cholesterol screening and invasive testing were up 20%; Return visits were up 20%.

Flu shots were significantly more likely.

M Alsan, O Garrick, and GC Graziani, NBER Working Paper No. 24787, June 2018, Revised September 2018
Race matters in perinatal mortality

1.8 million hospital births in Florida between 1992 and 2015; Black newborn deaths are 3x greater than that of whites

Patient–physician concordance benefitted Black newborns with Black physicians by 53-56% compared to discordant care

No significant improvement in maternal mortality based on racial concordance

PNAS September 1, 2020 117 (35) 20975-20976
Fewer Black and Asian family medicine physicians practice obstetrical care

Family medicine physicians deliver a great deal of obstetrical care across the country. Black FM physicians are half as likely (OR 0.55, CI 0.41-0.74) to provide obstetrical care as part of their practice compared to White and Latinx physicians. Less likely to maintain continuing certification for obstetrical practice.

A diverse and racially/ethnically representative maternity care workforce, including family physicians, may help to ameliorate disparities in maternal and birth outcomes. Enhanced efforts to diversify the family physician maternity care workforce should be implemented.

Concordance and Communication

Information seeking was higher among Black participants after they viewed messages from Black physicians.

Supports the important role that health professionals and other leaders in communities of color play in enhancing the acceptance of COVID-19 vaccination and other interventions.

Concordance across dimensions other than ethnicity may be more important for Latinx patients.

Ensuring that messages are accurate, available, and comprehensible is insufficient—recipients must also trust the messenger. Trust is most likely when information is delivered by a messenger who is known and has a positive relationship with the community.


Patient-centered communication does not explain heightened satisfaction in concordance

Race-concordant visits are longer and characterized by more patient positive affect.

This is linked to continuity of care

Association between race concordance and higher patient ratings of care is independent of patient-centered communication, suggesting that other factors, such as patient and physician attitudes, may mediate the relationship

Patients are requesting concordant care

Step 1: Acknowledge Race and Racism In The Room
Step 2: Create a Care Plan Anticipating That Racism May Impact Pregnancy
Step 3: Identify How Racism May Impact Labor
Step 4: Identify How Racism May Impact Postpartum

Racial concordance contributes to a more effective therapeutic relationship and improved healthcare

Of the 50,626 adults in the analysis sample, 32,350 had racial concordance with their clinician.

Asian and Hispanic patients, low income, less education, and non-private insurance were associated with an increased likelihood of patient-clinician racial concordance.

Emergency department use was lower among Whites and Hispanics with concordant clinicians compared to those without a discordant clinician (15.6% vs. 17.3%, \(p = 0.02\) and 12.9% vs. 16.2%, \(p = 0.01\) respectively).

Total healthcare expenditures were lower among Black, Asian, and Hispanic patients with race-concordant clinicians than those with discordant clinicians (14%, 34%, and 20%, \(p < 0.001\) respectively).

Racial disparities in postpartum pain management

9,900 postpartum women were eligible for analysis. Compared with non-Hispanic white women, Hispanic and non-Hispanic black women had significantly greater odds of reporting a pain score of 5 or higher (adjusted odds ratio [aOR] 1.61, 95% 1.26-2.06 and aOR 2.18, 95% 1.63-2.91, respectively) but received significantly fewer inpatient MMEs/d (adjusted β -5.03, 95% CI -6.91 to -3.15, and adjusted β -3.54, 95% CI -5.88 to -1.20, respectively).

Hispanic and non-Hispanic black women were significantly less likely to receive an opioid prescription at discharge (aOR 0.80, 95% CI 0.67 to -0.96 and aOR 0.78, 95% CI 0.62-0.98) compared with non-Hispanic white women.

Hispanic and non-Hispanic black women experience disparities in pain management in the postpartum setting that cannot be explained by less perceived pain.

Conclusions

Create or expand funded measures to support increasing diversity of historically marginalized individuals in health careers and medicine

Recognize the value of communication, trust and safety and educate all physicians as to how they may deliver better care with cultural humility

Ensure that performance measures valid, fair and nonpunitive to marginalized physicians due to their patients’ greater influence from the social determinants of health and politics

Consider incentivizing non-marginalized physicians to work in communities of marginalized patients, because some care is better than no care. But ensure these individuals have the cultural dexterity to manage complex relationships with untrusting patients. Trust is earned.