Racially Concordant Care

William McDade, MD, PhD
Chief Diversity, Equity and Inclusion Officer
Accreditation Council for Graduate Medical Education

Care provided by a physician who shares the racial identity of the patient

Why do individuals seek out physicians of their same race/ethnicity/religion?

- Comfort/familiarity
- Language concordance/ communication
- Safety- psychological, physical
- Trust, respect
- Shared world-view
- Proximal location

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

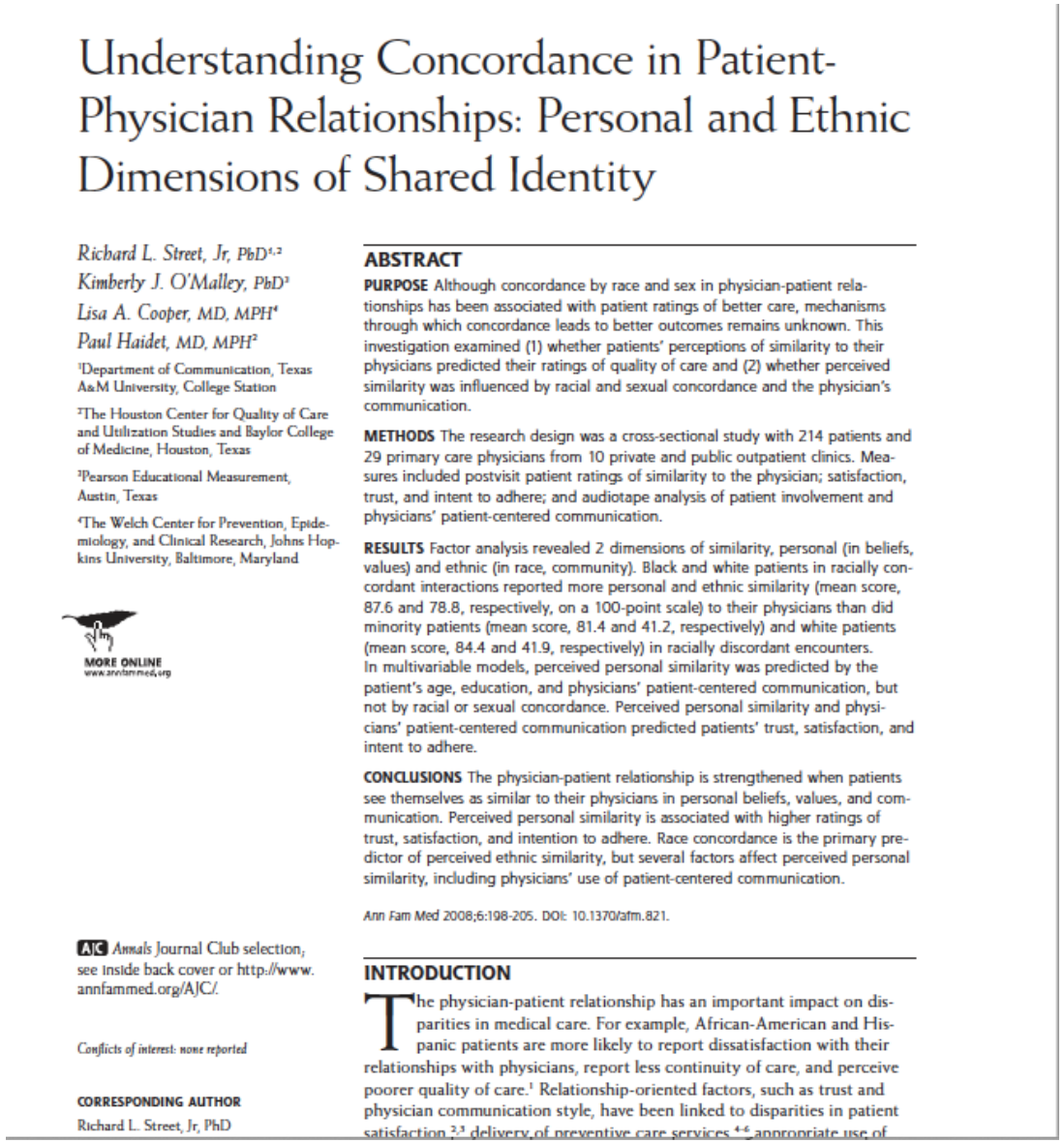
Black women were more likely to report unfair treatment and discrimination within the health care system than white women and Latina women

[1]C. Sakala, E.R. Declercq, et al., *Listening to Mothers in Cali- fornia: A Population-Based Survey of Women’s Childbearing Experiences* (National Partnership for Women and Families, 2019)

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



Understanding Concordance in Patient-Physician Relationships: Personal and Ethnic Dimensions of Shared Identity

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[4]The Welch Center for Prevention, Epidemiology, and Clinical Research, Johns Hopkins University, Baltimore, Maryland

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ABSTRACT

PURPOSE Although concordance by race and sex in physician-patient relationships has been associated with patient ratings of better care, mechanisms through which concordance leads to better outcomes remains unknown. This investigation examined (1) whether patients' perceptions of similarity to their physicians predicted their ratings of quality of care and (2) whether perceived similarity was influenced by racial and sexual concordance and the physician's communication.

METHODS The research design was a cross-sectional study with 214 patients and 29 primary care physicians from 10 private and public outpatient clinics. Measures included postvisit patient ratings of similarity to the physician; satisfaction, trust, and intent to adhere; and audiotape analysis of patient involvement and physicians' patient-centered communication.

RESULTS Factor analysis revealed 2 dimensions of similarity, personal (in beliefs, values) and ethnic (in race, community). Black and white patients in racially concordant interactions reported more personal and ethnic similarity (mean score, 87.6 and 78.8, respectively, on a 100-point scale) to their physicians than did minority patients (mean score, 81.4 and 41.2, respectively) and white patients (mean score, 84.4 and 41.9, respectively) in racially discordant encounters. In multivariable models, perceived personal similarity was predicted by the patient's age, education, and physicians' patient-centered communication, but not by racial or sexual concordance. Perceived personal similarity and physicians' patient-centered communication predicted patients' trust, satisfaction, and intent to adhere.

CONCLUSIONS The 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, but several factors affect perceived personal similarity, including physicians' use of patient-centered communication.

Ann Fam Med 2008;6:198-205. DOI: 10.1370/afm.821.

AJC *Annals* Journal Club selection; see inside back cover or http://www.annfammed.org/AJC/.

Conflicts of interest: none reported

CORRESPONDING AUTHOR
Richard L. Street, Jr, PhD

INTRODUCTION

The physician-patient relationship has an important impact on disparities in medical care. For example, African-American and Hispanic patients are more likely to report dissatisfaction with their relationships with physicians, report less continuity of care, and perceive poorer quality of care.[1] Relationship-oriented factors, such as trust and physician communication style, have been linked to disparities in patient satisfaction,[2,3] delivery of preventive care services,[4-6] appropriate use of

Street, R.L., O'Malley, K.J., Cooper, L.A. and Haidet, P., 2008. Understanding concordance in patient-physician relationships: personal and ethnic dimensions of shared identity. *The Annals of Family Medicine*, *6*(3), pp.198-205.

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

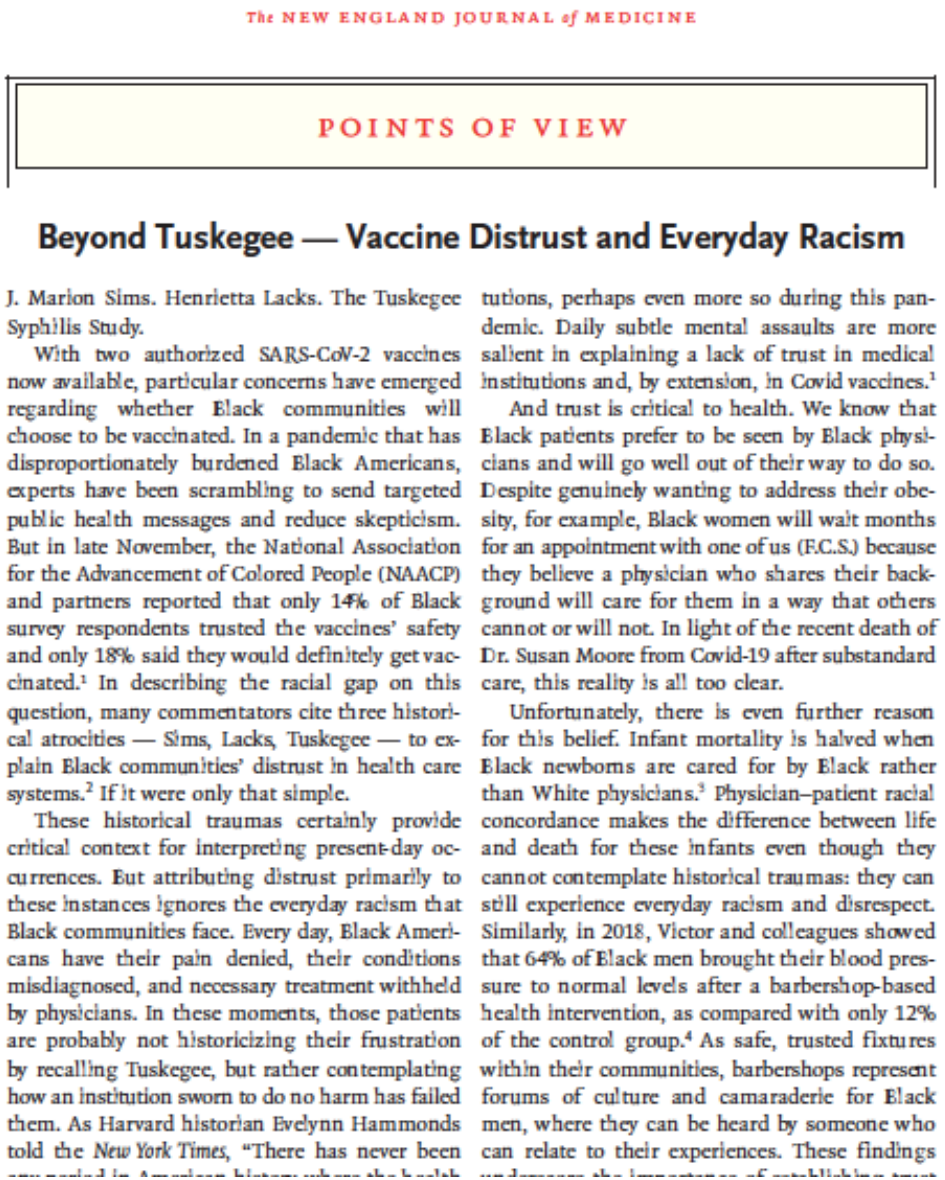
Improved clinical outcomes in some categories has been shown

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.



The NEW ENGLAND JOURNAL of MEDICINE

POINTS OF VIEW

Beyond Tuskegee — Vaccine Distrust and Everyday Racism

J. Marion Sims. Henrietta Lacks. The Tuskegee Syphilis Study.

With two authorized SARS-CoV-2 vaccines now available, particular concerns have emerged regarding whether Black communities will choose to be vaccinated. In a pandemic that has disproportionately burdened Black Americans, experts have been scrambling to send targeted public health messages and reduce skepticism. But in late November, the National Association for the Advancement of Colored People (NAACP) and partners reported that only 14% of Black survey respondents trusted the vaccines' safety and only 18% said they would definitely get vaccinated.[1] In describing the racial gap on this question, many commentators cite three historical atrocities — Sims, Lacks, Tuskegee — to explain Black communities' distrust in health care systems.[2] If it were only that simple.

These historical traumas certainly provide critical context for interpreting present-day occurrences. But attributing distrust primarily to these instances ignores the everyday racism that Black communities face. Every day, Black Americans have their pain denied, their conditions misdiagnosed, and necessary treatment withheld by physicians. In these moments, those patients are probably not historicizing their frustration by recalling Tuskegee, but rather contemplating how an institution sworn to do no harm has failed them. As Harvard historian Evelynn Hammonds told the *New York Times*, "There has never been

tutions, perhaps even more so during this pandemic. Daily subtle mental assaults are more salient in explaining a lack of trust in medical institutions and, by extension, in Covid vaccines.[1]

And trust is critical to health. We know that Black patients prefer to be seen by Black physicians and will go well out of their way to do so. Despite genuinely wanting to address their obesity, for example, Black women will wait months for an appointment with one of us (F.C.S.) because they believe a physician who shares their background will care for them in a way that others cannot or will not. In light of the recent death of Dr. Susan Moore from Covid-19 after substandard care, this reality is all too clear.

Unfortunately, there is even further reason for this belief. Infant mortality is halved when Black newborns are cared for by Black rather than White physicians.[3] Physician–patient racial concordance makes the difference between life and death for these infants even though they cannot contemplate historical traumas: they can still experience everyday racism and disrespect. Similarly, in 2018, Victor and colleagues showed that 64% of Black men brought their blood pressure to normal levels after a barbershop-based health intervention, as compared with only 12% of the control group.[4] As safe, trusted fixtures within their communities, barbershops represent forums of culture and camaraderie for Black men, where they can be heard by someone who can relate to their experiences. These findings

Bajaj, S.S. and Stanford, F.C., 2021. Beyond Tuskegee—Vaccine Distrust and Everyday Racism. *NEJM*, p.e11.

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]

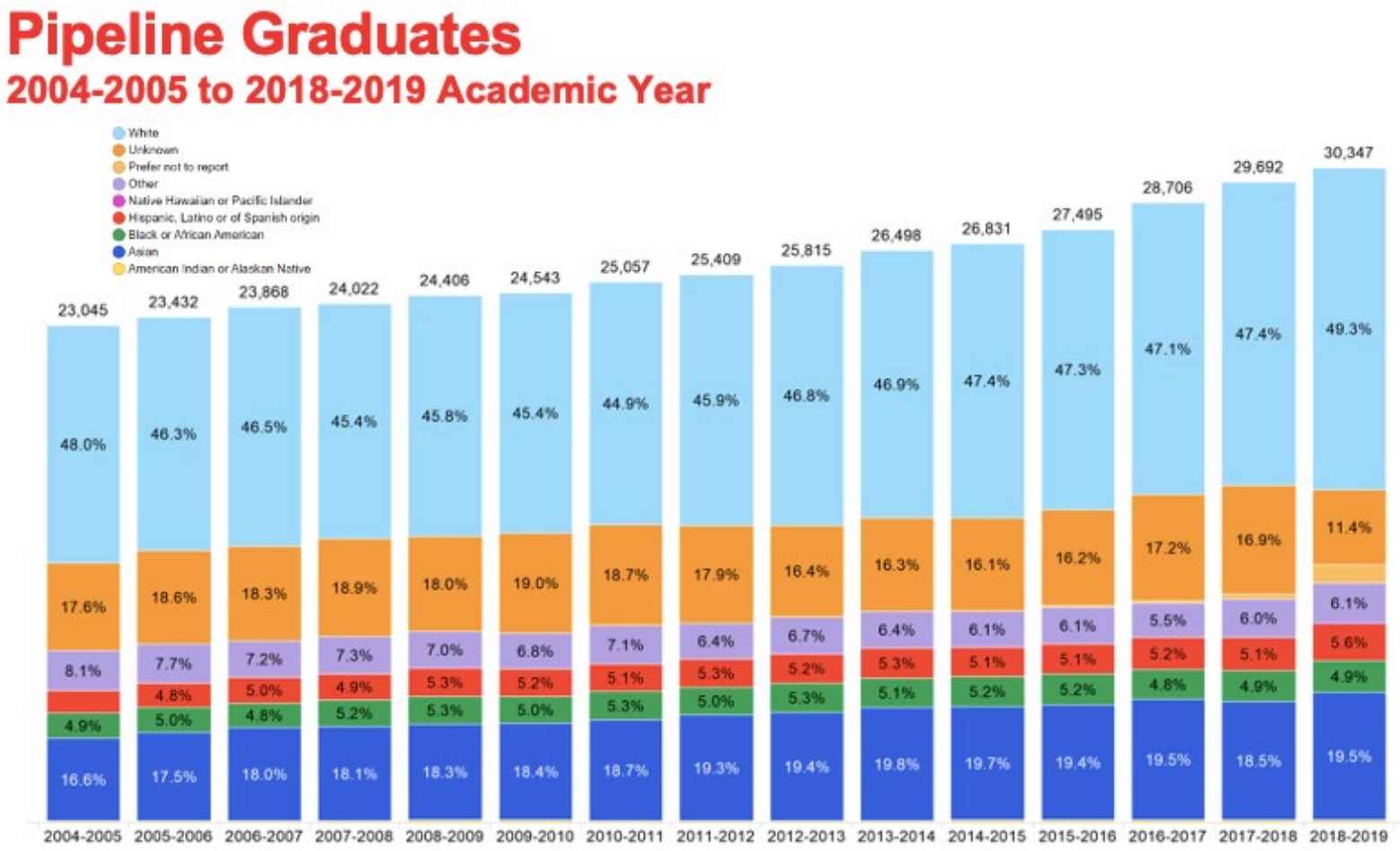
[1]Pronk, N.P., Kleinman, D.V. and Richmond, T.S., 2021. Healthy People 2030: Moving toward equitable health and well-being in the United States. *EClinicalMedicine*, *33*.

[2]Dawes, D.E., 2020. *The political determinants of health*. Johns Hopkins University Press.

Hazard of depending on racially concordant care to eliminate health disparities, cont'd

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

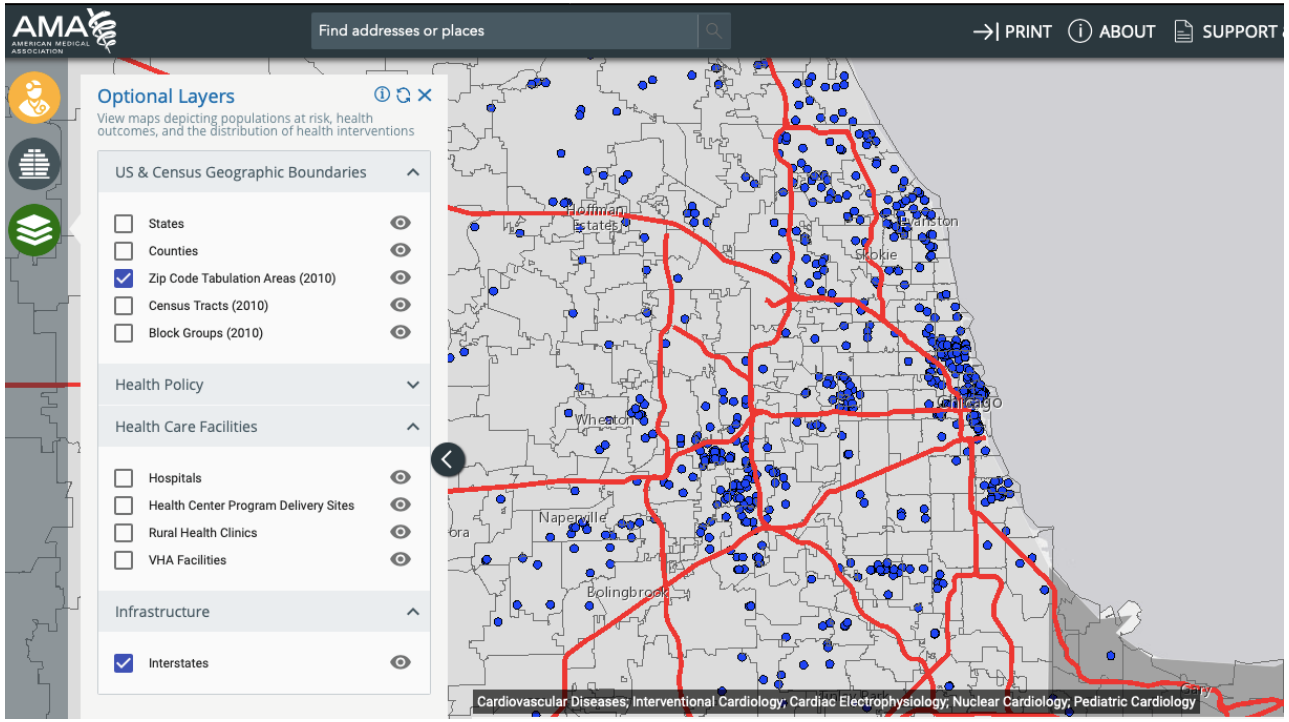


Workforce Diversity matters to the elimination of health disparities

- 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

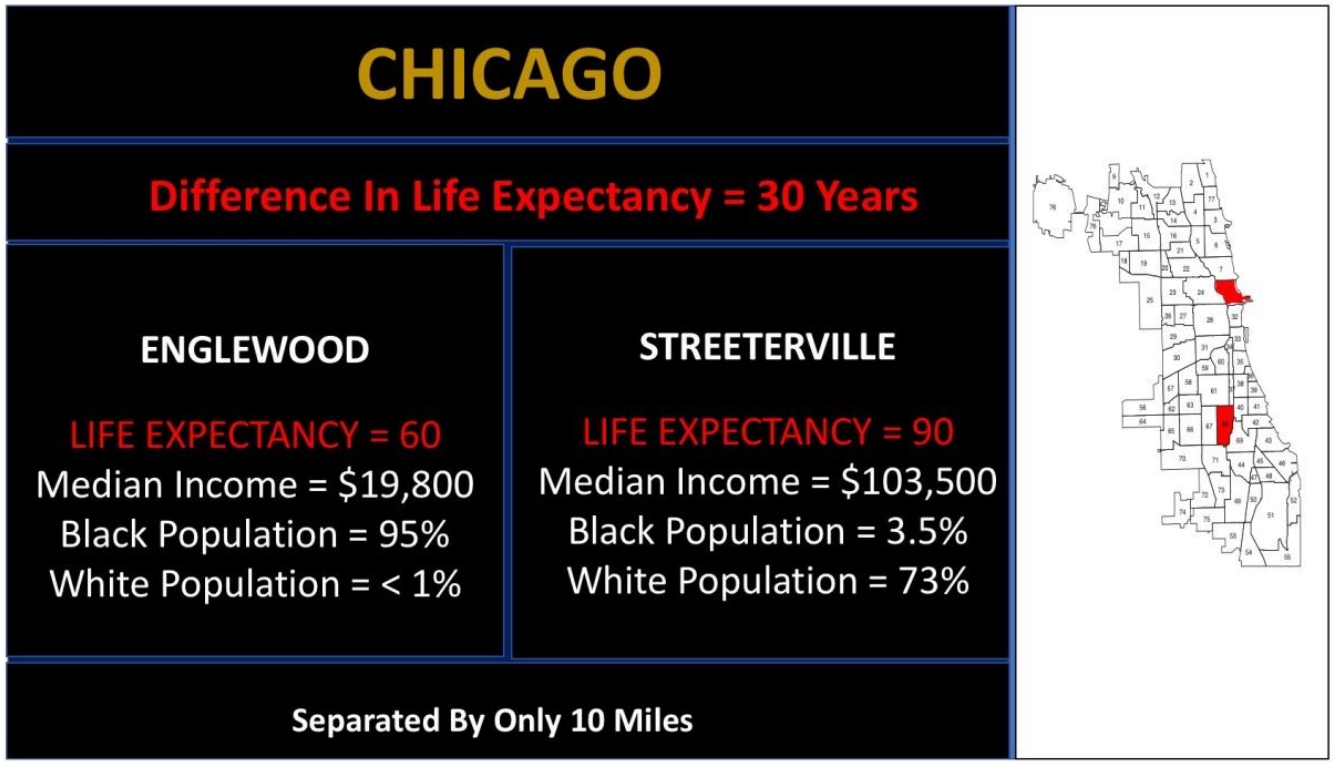
Inverse association between where physicians practice and where disease burden is greatest



AMA Health Workforce Mapper

- 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.



NYT 5 Sept 2020

https://www.nytimes.com/interactive/2020/09/05/opinion/inequality-life-expectancy.html

- 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

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

Gaskin, D.J., Dinwiddie, G.Y., Chan, K.S. and McCleary, R.R., 2012. Residential segregation and the availability of primary care physicians. Health services research, 47(6), pp.2353-2376.

HSR Health Services Research

DOI: 10.1111/j.1475-6773.2012.01417.x
RESEARCH ARTICLE

Residential Segregation and the Availability of Primary Care Physicians

Darrell J. Gaskin, Gniesha Y. Dinwiddie, Kitty S. Chan, and Rachael R. McCleary

Objective. To examine the association between residential segregation and geographic access to primary care physicians (PCPs) in metropolitan statistical areas (MSAs).

Data Sources. We combined zip code level data on primary care physicians from the 2006 American Medical Association master file with demographic, socioeconomic, and segregation measures from the 2000 U.S. Census. Our sample consisted of 15,465 zip codes located completely or partially in an MSA.

Methods. We defined PCP shortage areas as those zip codes with no PCP or a population to PCP ratio of >3,500. Using logistic regressions, we estimated the association between a zip code's odds of being a PCP shortage area and its minority composition and degree of segregation in its MSA.

Principal Findings. We found that odds of being a PCP shortage area were 67 percent higher for majority African American zip codes but 27 percent lower for majority Hispanic zip codes. The association varied with the degree of segregation. As the degree of segregation increased, the odds of being a PCP shortage area increased for majority African American zip codes; however, the converse was true for majority Hispanic and Asian 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

EXHIBIT 2

Average percentage of patient populations treated by underrepresented minority dentists, by race/ethnicity

	Clinically active dentists (N = 11,408)			
Patient population	**Black**	**American Indian or Alaska Native**	**Hispanic or Latino**	**All**
Black	44.9%	12.8%	13.0%	29.2%
American Indian or Alaska Native	3.7	20.4	3.9	4.7
Hispanic or Latino	19.8	13.7	41.8	30.1
All underrepresented minority	58.8	37.7	50.5	54.1
White	30.9	54.6	39.5	35.8
Asian	5.9	8.2	6.4	6.2

SOURCE Authors' analysis of data from the 2012 underrepresented minority dentist survey.

Mertz, E.A., Wides, C.D., Kottek, A.M., Calvo, J.M. and Gates, P.E., 2016. Underrepresented minority dentists: quantifying their numbers and characterizing the communities they serve. *Health Affairs*, *35*(12), pp.2190-2199.

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

U.S.News HEALTH » Hospitals Hospital Heroes Doctors Senior Care Wellness Diets Conditio

Health / Best Hospitals

Who Gets High Quality Hospital Care?

A look at racial disparities in access to surgical care.

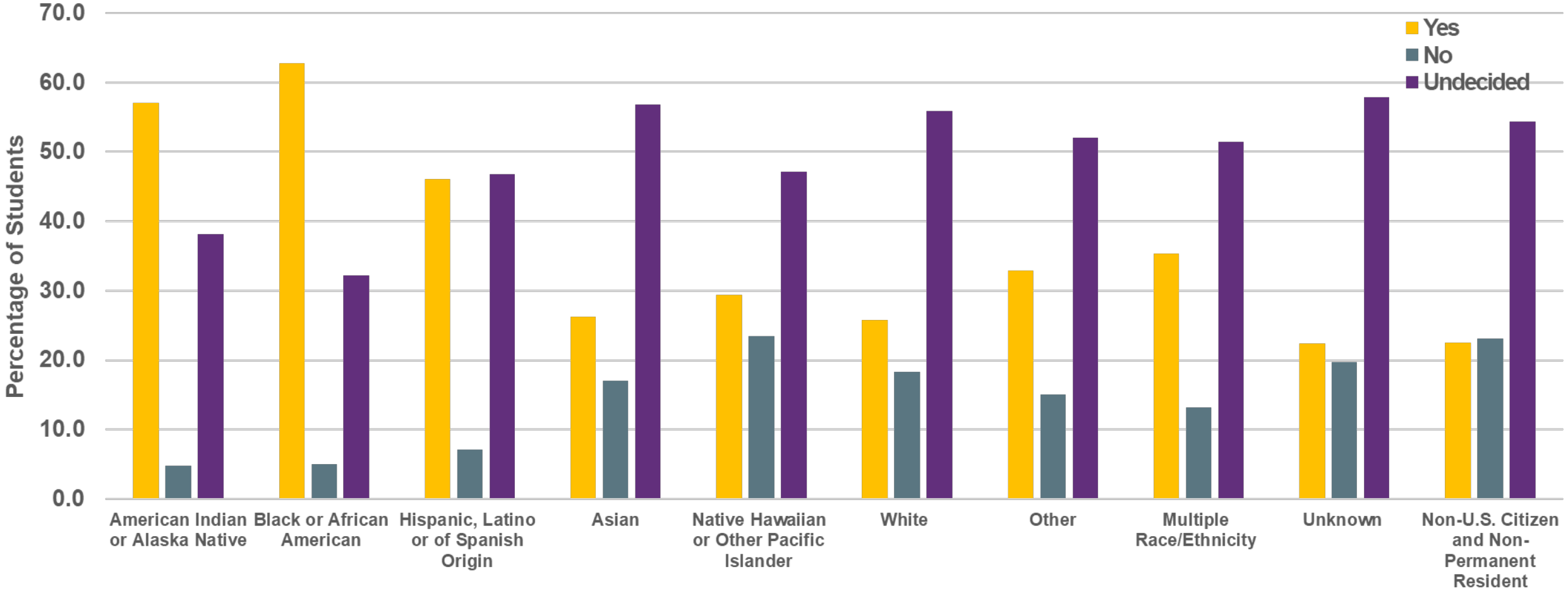
By **Anwesha Majumder** and **Ronan Corgel** July 28, 2020, at 12:00 a.m.

A U.S. NEWS ANALYSIS OF seven years of Medicare records reveals broad and enduring racial disparities in who receives surgical care and in the quality of the hospitals where people of different races tend to get treated. These new findings build on many years of scientific research that has exposed racial disparities in access to health care. Among U.S. News' key findings:

- Racial disparities in access to care exist in Medicare inpatients age 65 and older across several cardiovascular, cancer and orthopedic procedures.
- These differences are particularly striking in cardiovascular and orthopedic care, where Black patients represented fewer than 5% of Medicare beneficiaries who received the examined treatments, approximately a third less often than would be expected given that Black patients represented 7.3% of all Medicare hospitalizations. This translated to Black patients receiving 20,400 fewer cardiovascular procedures and 67,000 fewer orthopedic procedures

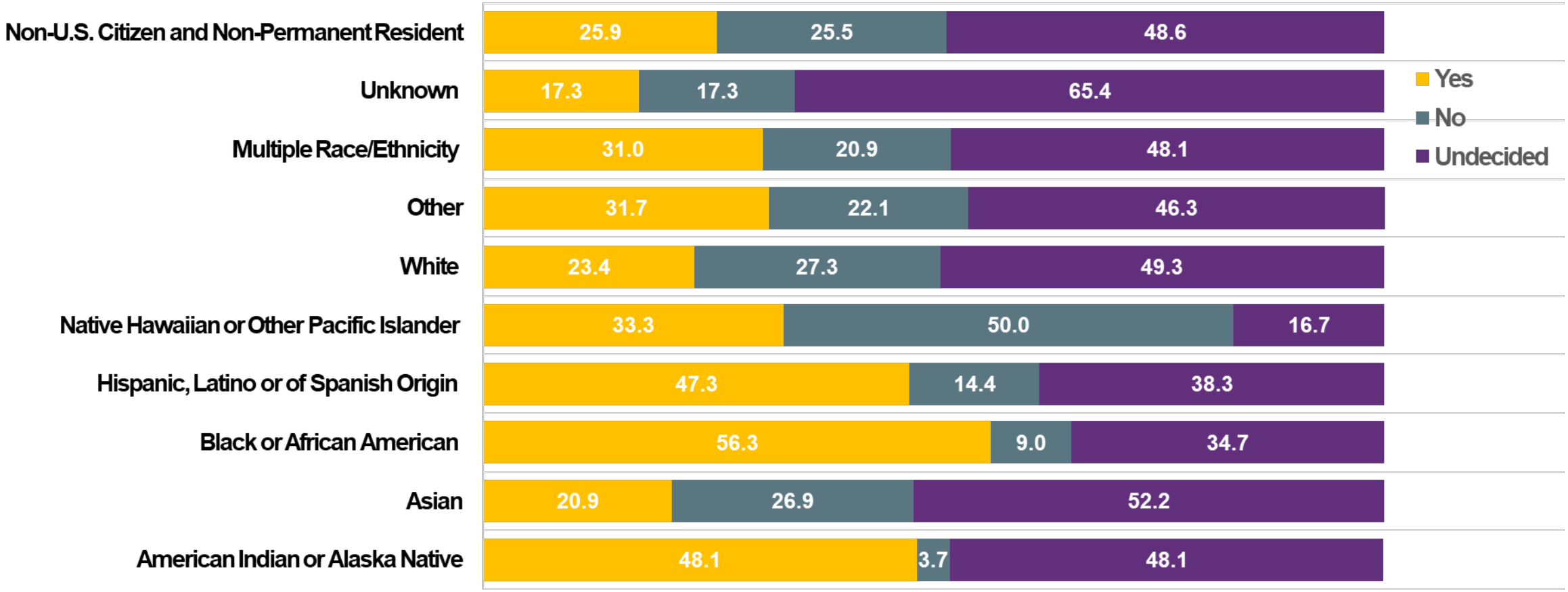
(GETTY IMAGES)

2019 MSQ Results: Do you plan to practice primarily in an underserved community?



AAMC: Data Warehouse, MSQ_R, GQ_R, and IND_IDENT_R tables as of December 30, 2020. MSQ_R last updated 1/9/2020. GQ_R last updated 8/26/2020. IND_IDENT_R last updated 12/3/2020.

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



AAMC: Data Warehouse, MSQ_R, GQ_R, and IND_IDENT_R tables as of December 30, 2020. MSQ_R last updated 1/9/2020. GQ_R last updated 8/26/2020. IND_IDENT_R last updated 12/3/2020.

Table 1. Unadjusted Association Between Disadvantaged Population and Receipt of Care From White vs Black, Hispanic, and Asian Physicians, Medical Expenditure Panel Survey, 2010

Patient Characteristic	No. (%)						
	Millions of Patients With a White Physician	Millions of Patients With a Black Physician	Unadjusted Odds Ratio (95% CI)[a]	Millions of Patients With a Hispanic Physician, No. (%)	Unadjusted Odds Ratio (95% CI)[b]	Millions of Patients With an Asian Physician, No. (%)	Unadjusted Odds Ratio (95% CI)[c]
All patients	62.2 (100.0)	3.3 (100.0)		5.9 (100.0)		9.8 (100.0)	
Non-Hispanic whites	53.2 (86.8)	1.1 (34.7)	1 [Reference]	2.4 (41.5)	1 [Reference]	5.2 (53.7)	1 [Reference]
Minorities	9.0 (13.2)	2.2 (65.3)	12.30 (8.30-18.00)	3.5 (58.5)	8.20 (5.98-11.23)	4.6 (46.3)	5.40 (4.16-6.99)
Black, non-Hispanic	4.1 (7.1)	1.9 (63.9)	23.24 (16.28-33.17)	0.5 (16.8)	2.65 (1.81-3.87)	1.0 (16.3)	2.56 (1.90-3.44)
Hispanic	3.1 (5.5)	0.1 (5.3)	0.96 (0.49-1.88)	2.7 (52.6)	19.04 (13.47-26.93)	1.1 (17.7)	3.68 (2.62-5.18)
Asian	0.9 (1.7)	0.1 (5.1)	3.06 (1.15-8.17)	0.3 (9.0)	5.63 (2.67 -11.86)	2.3 (31.2)	25.73 (16.92 -39.13)
Other	0.9 (1.7)	0.1 (7.4)	4.60 (1.78-11.94)	0.02 (1.1)	0.61 (0.17 -2.15)	0.2 (3.8)	2.25 (1.19-4.25)
Income							
High/middle	48.9 (78.5)	2.1 (64.5)	1 [Reference]	3.9 (65.5)	1 [Reference]	7.0 (70.9)	1 [Reference]
Low	13.4 (21.5)	1.2 (35.5)	2.03 (1.46-2.75)	2.1 (34.5)	1.92 (1.44-2.55)	2.8 (29.1)	1.49 (1.23-1.81)
Medicaid							
None	54.8 (93.2)	2.5 (78.4)	1 [Reference]	4.4 (81.8)	1 [Reference]	7.9 (85.2)	1 [Reference]
Medicaid	4.0 (6.8)	0.7 (21.6)	3.75 (2.72-5.18)	1.0 (18.2)	3.04 (2.29-4.04)	1.4 (14.8)	2.38 (1.85-3.06)
Any health insurance	58.8 (94.3)	3.1 (95.2)	1 [Reference]	5.4 (90.1)	1 [Reference]	9.3 (94.0)	1 [Reference]
Uninsured	3.5 (5.7)	0.1 (4.8)	0.83 (0.49-1.41)	0.6 (9.9)	1.83 (1.30-2.57)	0.6 (6.0)	1.07 (0.78-1.47)
English home language	60.6 (97.3)	3.2 (96.8)	1 [Reference]	3.9 (66.7)	1 [Reference]	7.9 (80.4)	1 [Reference]
Non-English home language	1.7 (2.7)	0.1 (3.2)	1.18 (0.51-2.69)	2.1 (33.4)	17.83 (12.80-24.82)	1.9 (19.6)	8.69 (6.19-12.19)

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

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

[c] Odds of patients in a demographic group reporting an Asian physician relative to non-Hispanic white patients reporting an Asian physician.

Marrast LM, et al. *JAMA Intern Med.* 2014;174(2):289-291.

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

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Primary Care Physicians Who Treat Blacks and Whites

Peter B. Bach, M.D., M.A.P.P., Hoangmai H. Pham, M.D., M.P.H., Deborah Schrag, M.D., M.P.H., Ramsey C. Tate, B.S., and J. Lee Hargraves, Ph.D.

ABSTRACT

BACKGROUND

In the United States, black patients generally receive lower-quality health care than white patients. Black patients may receive their care from a subgroup of physicians whose qualifications or resources are inferior to those of the physicians who treat white patients.

METHODS

We performed a cross-sectional analysis of 150,391 visits by black Medicare beneficiaries and white Medicare beneficiaries 65 years of age or older for medical "evaluation and management" who were seen by 4355 primary care physicians who participated in a biannual telephone survey, the 2000–2001 Community Tracking Study Physician Survey.

RESULTS

Most visits by black patients were with a small group of physicians (80 percent of visits were accounted for by 22 percent of physicians) who provided only a small percentage of care to white patients. In a comparison of visits by white patients and black patients, we found that the physicians whom the black patients visited were less likely to be board certified (77.4 percent) than were the physicians visited by the white patients (86.1 percent, P=0.02) and also more likely to report that they were unable to provide high-quality care to all their patients (27.8 percent vs. 19.3 percent, P=0.005). The physicians treating black patients also reported facing greater difficulties in obtaining access for their patients to high-quality subspecialists, high-quality diagnostic imaging, and nonemergency admission to the hospital.

Bach, PB et al. N Engl J Med 2004;351:575-84.

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

Choice, exclusion or market?

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?

Powers, BW et al. Academic Medicine 2016. 91(7):913-5

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

Does Diversity Matter for Health?
Experimental Evidence from Oakland*

Marcella Alsan† Owen Garrick‡ Grant Graziani§

June 2018

Abstract

We study the effect of diversity in the physician workforce on the demand for preventive care among African-American men. Black men have the lowest life expectancy of any major demographic group in the U.S., and much of the disadvantage is due to chronic diseases which are amenable to primary and secondary prevention. In a field experiment in Oakland, California, we randomize black men to black or non-black male medical doctors and to incentives for one of the five offered preventives — the flu vaccine. We use a two-stage design, measuring decisions about cardiovascular screening and the flu vaccine before (ex ante) and after (ex post) meeting their assigned doctor. Black men select a similar number of preventives in the ex-ante stage, but are much more likely to select every preventive service, particularly invasive services, once meeting with a doctor who is the same race. The effects are most pronounced for men who mistrust the medical system and for those who experienced greater hassle costs associated with their visit. Subjects are more likely to talk with a black doctor about their health problems and black doctors are more likely to write additional notes about the subjects. The results are most consistent with better patient-doctor communication during the encounter rather than differential quality of doctors or discrimination. Our findings suggest black doctors could help reduce cardiovascular mortality by 16 deaths per 100,000 per year — leading to a 19% reduction in the black-white male gap in cardiovascular mortality.

JEL Classification Codes: I12, I14, C93
Keywords: Homophily, social distance, mistrust, behavioral misperceptions, health gradients

*We thank Pascaline Dupas and the J-PAL Board and Reviewers who provided important feedback that improved the design and implementation of the experiment. We thank Jeremy Bulow, Kate Casey, Arun Chandrasekhar, Raj Chetty, Karen Eggleston, Erica Field, Michael Greenstone, Seema Jayachandran, Damon Jones, Melanie Morten, Maria Polyakova, Al Roth, Kosali Simon, Ebonya Washington and Crystal Yang for their helpful comments. Javarcia Ivory, Matin Mirramezani, Edna Idna, Anlu Xing and especially Morgan Foy provided excellent research assistance. We thank the study doctors and field staff team for their participation and dedication. We thank the administration at Stanford and J-PAL particularly Lesley Chang, Rhonda McClinton-Brown, Dr. Mark Cullen, Dr. Douglas K. Owens, Ann Dohn, Ashima Goel, Atty. Ann James, Atty. Tina Dobleman, Nancy Lonhart, Jason Bauman and Sophie Shank. The study was made possible by a grant through the Abdul Latif Jameel Poverty Action Lab - Health

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

Physician–patient racial concordance and disparities in birthing mortality for newborns

Brad N. Greenwood[a,1,2], Rachel R. Hardeman[b,1], Laura Huang[c,1], and Aaron Sojourner[d,1]

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Edited by Christopher W. Kuzawa, Northwestern University, Evanston, IL, and approved July 16, 2020 (received for review August 2, 2019)

Recent work has emphasized the benefits of patient–physician concordance on clinical care outcomes for underrepresented minorities, arguing it can ameliorate outgroup biases, boost communication, and increase trust. We explore concordance in a setting where racial disparities are particularly severe: childbirth. In the United States, Black newborns die at three times the rate of White newborns. Results examining 1.8 million hospital births in the state of Florida between 1992 and 2015 suggest that newborn–physician racial concordance is associated with a significant improvement in mortality for Black infants. Results further suggest that these benefits manifest during more challenging births and in hospitals that deliver more Black babies. We find no significant improvement in maternal mortality when birthing mothers share race with their physician.

racial bias | birthing outcomes | concordance | mortality | health care

The relationship between a decision maker's ascriptive characteristics and advocates who do or do not share those characteristics has long been a source of intense scrutiny by scholars across a wide range of disciplines. Researchers in sociology have noted the benefits of female leadership for young women working at firms (1, 2). Management scholars note increased leniency in enforcing regulatory compliance when inspectors and their targets share similar backgrounds (3). Economists have shown that academic performance is higher when students share race with teachers (4). In addition, legal scholars have found higher incarceration rates among defendants paired with judges of a different race (5).

However, despite the prevalence of these findings, little evidence on the effect of gender and racial concordance in medicine existed until recently. Although received work indicates approaches to address this pressing social issue. Furthermore, to the extent that newborns cannot verbally communicate with their physician, we are able to observe the effects of concordance without trust or communication issues affecting the patient–physician relationship. Inasmuch as prior research has struggled to disentangle the mechanisms behind concordance's effect (10, 26), the setting allows us to explore concordance in the absence of one invoked mechanism—communication. Thus, if concordance effects manifest, we are able to rule out communication as the exclusive mechanism.

Research posits that racial concordance between a newborn and their physician may mitigate disparities for at least two reasons. First, research suggests concordance is not only salient for adults. Indeed, a growing body of literature explores the question of whether actors exhibit different levels of bias toward both children and adults. Wolf et al. (27), for example, examine whether adults' spontaneous racial bias toward children differs from their spontaneous racial bias toward adults, finding that people have significantly greater favorability toward their ingroup. Strikingly, this bias was exhibited equally toward adults and children. It is therefore possible that such an effect might manifest exclusively as a function of spontaneous bias. At the same time, extant research indicates that mortality across White and Black newborns is starkly different (28), suggesting Black newborns may have different needs and be more medically challenging to treat due to social risk factors and cumulative racial and socioeconomic disadvantages of Black pregnant women (29). To the extent that physicians of a social outgroup are more likely to be aware of the challenges and issues that arise when treating their group (10, 30, 31), it stands to reason that these physicians may be more equipped to treat patients with complex needs.

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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

Eden, A.R., Taylor, M.K., Morgan, Z.J. and Barreto, T., 2021. Racial and Ethnic Diversity of Family Physicians Delivering Maternity Care. *Journal of Racial and Ethnic Health Disparities*, pp.1-7.

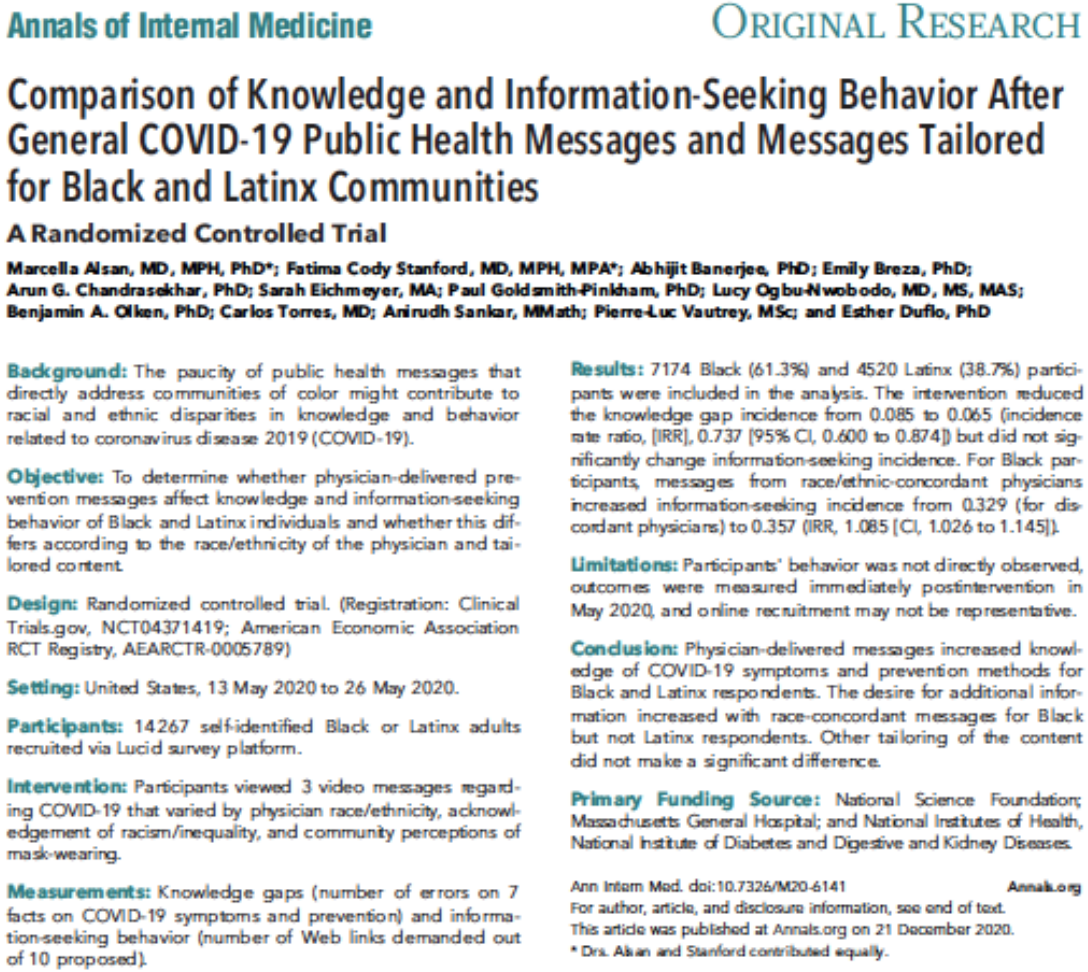
Concordance and Communication

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.



Annals of Internal Medicine ORIGINAL RESEARCH

Comparison of Knowledge and Information-Seeking Behavior After General COVID-19 Public Health Messages and Messages Tailored for Black and Latinx Communities

A Randomized Controlled Trial

Marcella Alsan, MD, MPH, PhD*; Fatima Cody Stanford, MD, MPH, MPA*; Abhijit Banerjee, PhD; Emily Breza, PhD; Arun G. Chandrasekhar, PhD; Sarah Eichmeyer, MA; Paul Goldsmith-Pinkham, PhD; Lucy Ogbu-Nwobodo, MD, MS, MAS; Benjamin A. Olken, PhD; Carlos Torres, MD; Anirudh Sankar, MMath; Pierre-Luc Vautrey, MSc; and Esther Duflo, PhD

Background: The paucity of public health messages that directly address communities of color might contribute to racial and ethnic disparities in knowledge and behavior related to coronavirus disease 2019 (COVID-19).

Objective: To determine whether physician-delivered prevention messages affect knowledge and information-seeking behavior of Black and Latinx individuals and whether this differs according to the race/ethnicity of the physician and tailored content.

Design: Randomized controlled trial. (Registration: Clinical Trials.gov, NCT04371419; American Economic Association RCT Registry, AEARCTR-0005789)

Setting: United States, 13 May 2020 to 26 May 2020.

Participants: 14 267 self-identified Black or Latinx adults recruited via Lucid survey platform.

Intervention: Participants viewed 3 video messages regarding COVID-19 that varied by physician race/ethnicity, acknowledgement of racism/inequality, and community perceptions of mask-wearing.

Measurements: Knowledge gaps (number of errors on 7 facts on COVID-19 symptoms and prevention) and information-seeking behavior (number of Web links demanded out of 10 proposed).

Results: 7174 Black (61.3%) and 4520 Latinx (38.7%) participants were included in the analysis. The intervention reduced the knowledge gap incidence from 0.085 to 0.065 (incidence rate ratio, [IRR], 0.737 [95% CI, 0.600 to 0.874]) but did not significantly change information-seeking incidence. For Black participants, messages from race/ethnic-concordant physicians increased information-seeking incidence from 0.329 (for discordant physicians) to 0.357 (IRR, 1.085 [CI, 1.026 to 1.145]).

Limitations: Participants' behavior was not directly observed, outcomes were measured immediately postintervention in May 2020, and online recruitment may not be representative.

Conclusion: Physician-delivered messages increased knowledge of COVID-19 symptoms and prevention methods for Black and Latinx respondents. The desire for additional information increased with race-concordant messages for Black but not Latinx respondents. Other tailoring of the content did not make a significant difference.

Primary Funding Source: National Science Foundation; Massachusetts General Hospital; and National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases.

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For author, article, and disclosure information, see end of text.
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* Drs. Alsan and Stanford contributed equally.

Alsan, Marcella, et al. "Comparison of Knowledge and Information-Seeking Behavior After General COVID-19 Public Health Messages and Messages Tailored for Black and Latinx Communities: A Randomized Controlled Trial." *Annals of internal medicine* (2020).

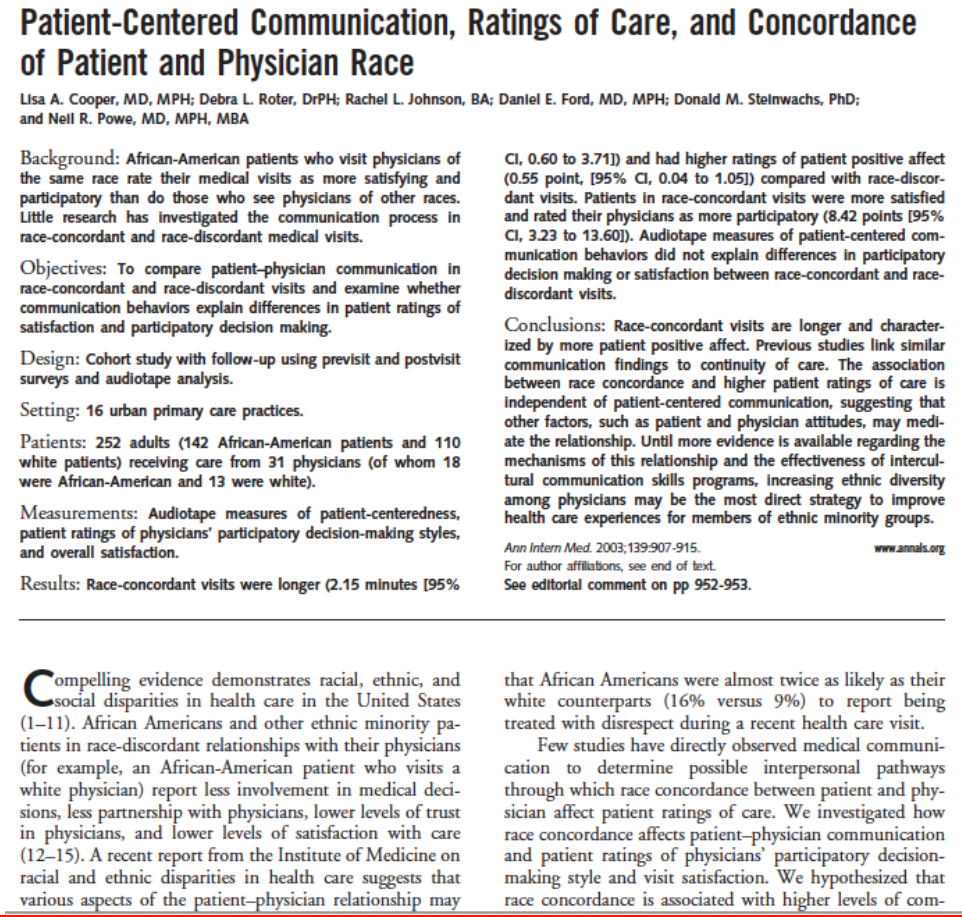
Cooper, Lisa A., and Catherine M. Stoney. "Messages to Increase COVID-19 Knowledge in Communities of Color: What Matters Most?." *Annals of Internal Medicine* (2020).

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



ARTICLE

Patient-Centered Communication, Ratings of Care, and Concordance of Patient and Physician Race

Lisa A. Cooper, MD, MPH; Debra L. Roter, DrPH; Rachel L. Johnson, BA; Daniel E. Ford, MD, MPH; Donald M. Steinwachs, PhD; and Neil R. Powe, MD, MPH, MBA

Background: African-American patients who visit physicians of the same race rate their medical visits as more satisfying and participatory than do those who see physicians of other races. Little research has investigated the communication process in race-concordant and race-discordant medical visits.

Objectives: To compare patient–physician communication in race-concordant and race-discordant visits and examine whether communication behaviors explain differences in patient ratings of satisfaction and participatory decision making.

Design: Cohort study with follow-up using previsit and postvisit surveys and audiotape analysis.

Setting: 16 urban primary care practices.

Patients: 252 adults (142 African-American patients and 110 white patients) receiving care from 31 physicians (of whom 18 were African-American and 13 were white).

Measurements: Audiotape measures of patient-centeredness, patient ratings of physicians' participatory decision-making styles, and overall satisfaction.

Results: Race-concordant visits were longer (2.15 minutes [95% CI, 0.60 to 3.71]) and had higher ratings of patient positive affect (0.55 point, [95% CI, 0.04 to 1.05]) compared with race-discordant visits. Patients in race-concordant visits were more satisfied and rated their physicians as more participatory (8.42 points [95% CI, 3.23 to 13.60]). Audiotape measures of patient-centered communication behaviors did not explain differences in participatory decision making or satisfaction between race-concordant and race-discordant visits.

Conclusions: Race-concordant visits are longer and characterized by more patient positive affect. Previous studies link similar communication findings to continuity of care. The 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. Until more evidence is available regarding the mechanisms of this relationship and the effectiveness of intercultural communication skills programs, increasing ethnic diversity among physicians may be the most direct strategy to improve health care experiences for members of ethnic minority groups.

Ann Intern Med. 2003;139:907-915. www.annals.org

For author affiliations, see end of text.

See editorial comment on pp 952-953.

Compelling evidence demonstrates racial, ethnic, and social disparities in health care in the United States (1–11). African Americans and other ethnic minority patients in race-discordant relationships with their physicians (for example, an African-American patient who visits a white physician) report less involvement in medical decisions, less partnership with physicians, lower levels of trust in physicians, and lower levels of satisfaction with care (12–15). A recent report from the Institute of Medicine on racial and ethnic disparities in health care suggests that various aspects of the patient–physician relationship may that African Americans were almost twice as likely as their white counterparts (16% versus 9%) to report being treated with disrespect during a recent health care visit.

Few studies have directly observed medical communication to determine possible interpersonal pathways through which race concordance between patient and physician affect patient ratings of care. We investigated how race concordance affects patient–physician communication and patient ratings of physicians' participatory decision-making style and visit satisfaction. We hypothesized that race concordance is associated with higher levels of com-

Cooper, L.A., Roter, D.L., Johnson, R.L., Ford, D.E., Steinwachs, D.M. and Powe, N.R., 2003. Patient-centered communication, ratings of care, and concordance of patient and physician race. *Annals of internal medicine*, *139*(11), pp.907-915.

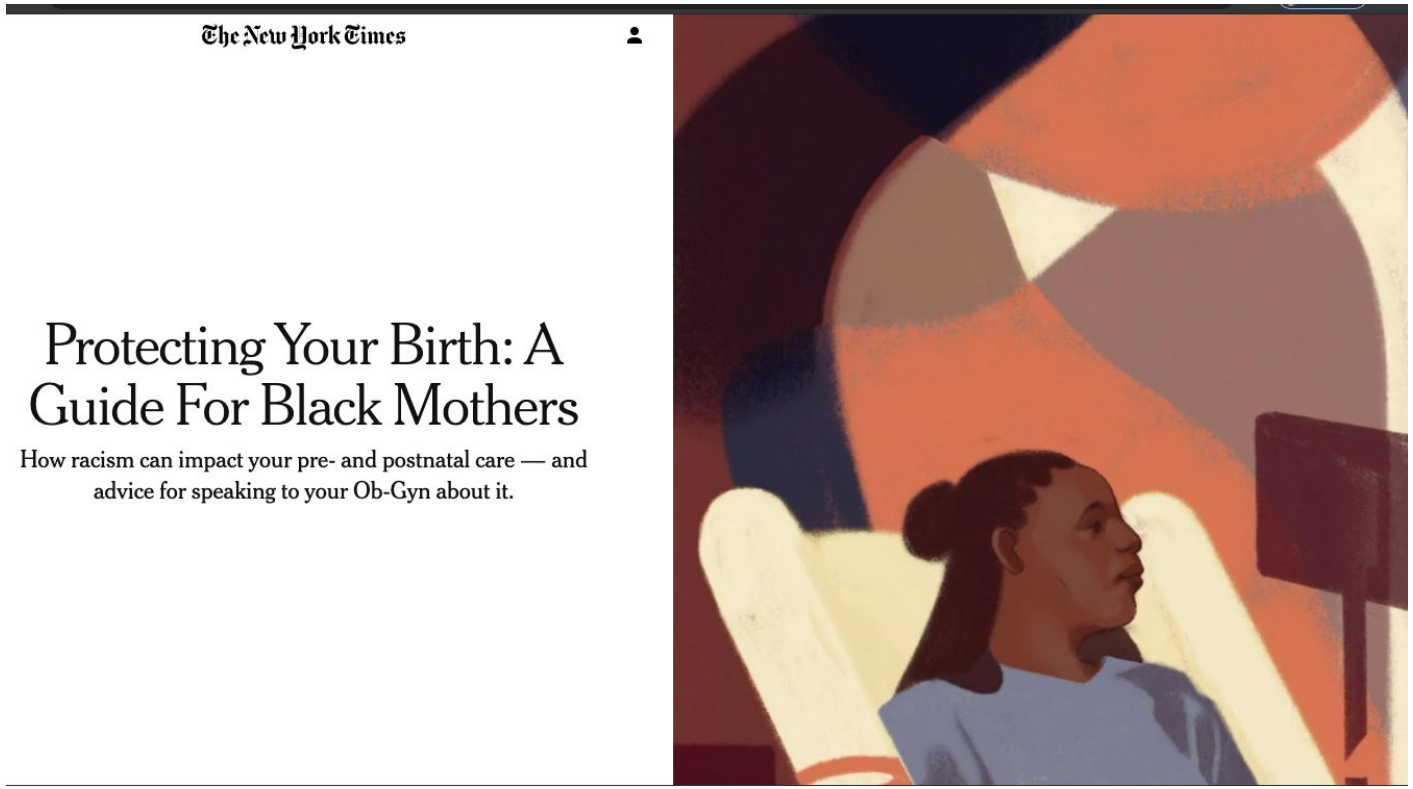
Patients are requesting concordant care

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



https://www.nytimes.com/article/black-mothers-birth.html?smid=url-share

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).

Jetty, A., Jabbarpour, Y., Pollack, J., Huerto, R., Woo, S. and Petterson, S., 2021. Patient-Physician Racial Concordance Associated with Improved Healthcare Use and Lower Healthcare Expenditures in Minority Populations. *Journal of racial and ethnic health disparities*, pp.1-14.

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.

Badreldin, N., Grobman, W.A. and Yee, L.M., 2019. Racial disparities in postpartum pain management. *Obstetrics and gynecology*, *134*(6), p.1147.

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.

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