SIDEBAR

Reducing Health Disparities: Is Concordant Care the Answer?

David G. Jacobs

Despite the fact that health disparities have existed since the founding of this country, these disparities have garnered significantly more attention over the past two decades, most notably as a result of the publishing of *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* by the Institute of Medicine in 2003. Not only did this monograph provide unequivocal evidence of the volume, variety, and extent of health disparities between Black and White Americans, it also provided several potential interventions that might be undertaken to mitigate these disparities. Among these recommendations was "Recommendation 5-3: Increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals" [1]. This, they believed, would bring about increased racial/ethnic concordance between minority patients and their health care providers, leading to enhanced patient-provider partnerships characterized by greater patient participation in care processes, higher patient satisfaction, and greater adherence to treatment [1].

Although research into the role of racial concordance in health care outcomes dates back only two decades, the concept was clearly articulated by Flexner in his well-known review of the state of medical education in 1910, in which he recommended that only two of the seven extant Black medical schools be preserved in order to train their students to "serve their people humbly" as "sanitarians" [2]. The first studies examining the role of racial concordance were published around the turn of the 21st-century and demonstrated that patients prefer racial concordance with their clinicians [3–5]. Since these early studies, hundreds have been published, using a variety of outcome measures (patient satisfaction, adherence, health care utilization), patient populations (primary care, surgery, obstetrics/gynecology, pediatrics, neonatology, mental health, emergency medicine, etc.), conditions and disease states (diabetes, hypertension, cancer screening and treatment, pain management, etc.), and research methodologies (surveys, actual health care utilization records, vignettes, prospective randomized studies). Studies have also sought to examine dimensions of patient-provider concordance other than race, most notably gender and language, although racial/ethnic concordance has received by far the greatest attention in the medical literature. Although the rigor of scientific investigation on this subject is low, and overall conclusions are mixed, the preponderance of data would suggest that racial concordance is associated with improvements in communication, which facilitates improved adherence to treatment plans, deeper partnership formation between patients and clinicians, more appropriate utilization of health care resources, and ultimately better health outcomes [6].

A recent review of Medical Expenditure Panel Survey data from 2010–2016 found that emergency department use was lower among Whites and Hispanics with race-concordant clinicians compared to those without a concordant clinician, and total health care expenditures were lower among Black, Asian, and Hispanic patients with race-concordant clinicians than those with discordant clinicians [6]. The most compelling evidence to date supporting better health outcomes is from a prospective observational study performed in Oakland, California, in which over 1300 Black men were recruited to participate in a free health screening [7]. Upon arriving for the screening, study participants were randomly assigned to see either a Black or non-Black male physician and were

Trust Between Clinicians and Administration

Health care administration takes place in the clinical setting as well as at the system, state, and federal levels. There are numerous reasons that trust has diminished between clinicians and administration. Clinicians and administrators often don't understand one another's day-to-day world, and administrative directives may arise with little opportunity for the clinical team to interact with the decision-makers. Mergers and acquisitions of hospitals and health systems have resulted in changing practice patterns, scheduling rubrics, and productivity requirements. If the clinical team does not understand organizational goals, those goals may appear to be for the benefit of the organization rather than clinical care [12].

To improve trust, health systems need to make their goals, strategies, and tactics more transparent to clinicians. In addition, trust would be improved by administration ensuring there are resources to support the implementation of clinical guidelines and quality measures. Clinicians need to express their needs directly and clearly. Improved understanding between clinicians and administrators will help improve the belief in the positive intent of the other party, reducing stress and increasing trust. Administrators and clinicians can spend time with one another so that all parties have a better understanding of the work of the other. Work should be done to align the values of administration and clinical care. Increased emphasis on quality and outcomes over financial and volume-productivity targets will improve collaboration and trust. Administrators and clinicians should

provided a photograph of that physician prior to the actual in-person screening. Physicians and staff were told the study was designed to improve the takeup of preventive care among Black men in Oakland, but not specifically informed about the role of physician race. Participants were then provided the opportunity to select which, if any, of four cardiovascular screening tests they would like to receive. After meeting with their assigned physician in person, study participants were given an opportunity to revise their choice of cardiovascular screening tests. Participants randomly assigned to Black physicians, after interacting with them, were 18 percentage points more likely to request cardiovascular screening tests—even invasive ones—relative to those assigned to Non-Black physicians [7]. While this study does not demonstrate actual improved health outcomes per se, the authors speculate that the increased demand for health care screening of Black males induced by racial/ethnic concordance could lead to a 19% reduction in the Black-White male cardiovascular mortality gap and an 8% decline in the Black-White male life expectancy gap [7]. Direct evidence of improved health outcomes was, however, provided in a more recent observational study in neonates that demonstrated lower mortality for Black newborns when Black doctors provide their care than when White doctors do [8].

Enhanced patient-provider communication is the most-commonly cited mechanism through which patient-provider racial/ethnic concordance exerts its purported benefit, though literature support for this proposed mechanism is mixed at best [9, 10]. Other suggested mechanisms include enhanced trust; shared cultural beliefs, values, and experiences; geographic proximity (facilitating easier access); decreased implicit bias; shared language (particularly for non-English speakers); greater patient self-efficacy; and overt racism (negative attitudes about "out-group" members). Future research should focus on elucidating the true mechanisms behind the "concordance effect," as these will be critical in the design and implementation of strategies to reduce health disparities.

An additional area of potential investigation involves the concept of intersectionality as it applies to concordance. How, for example, is concordance defined for individuals who claim multiple dimensions of "otherness" (for example: Hispanic ethnicity, female gender, and LGBTQIA+ sexual identity)? What does concordance look like for these individuals? These issues are particularly pertinent today in light of the current demographics of the US physician workforce. Focusing just on race/ethnicity momentarily, even if patient-provider concordance does indeed provide all of the benefits its advocates claim, there are simply not enough underrepresented-in-medicine (URiM) physicians to provide the primary care required by their respective patient populations, let alone subspecialty care. Currently, Blacks represent approximately 13.6% of the US population, but only 5.7% of the US physician population [11]. Likewise, Hispanics account for 18.9% of the US population, but only 6.9% of the US physician population [12]. Current trends in medical school enrollment will not correct this racial/ethnic imbalance in the physician workforce in the foreseeable future.

Furthermore, the concordance approach seems to assume that the Asian and Hispanic populations in America are monolithic. We should not assume that a patient of Mexican heritage and a physician of Puerto Rican descent will automatically be able to establish a deep and productive partnership simply because both are assigned "Hispanic" ethnicity. Similarly, there are many nationalities represented within the "Asian" race, and it is at best naive of us to assume that all Asians should be considered collectively when exploring the concept of concordance. Thus, patient-provider racial/ethnic concordance cannot be the sole response to health care disparities in America. If, indeed, enhanced patient-provider communication is the mechanism through which patient-provider racial/ethnic concordance exerts its purported benefit, then Recommendation 6-1 from *Unequal Treatment* ("Integrate cross-cultural education into the training of all current and future health professionals"), deserves attention equal to

feel that they are doing the right thing for the right reason, and the move from pay-for-volume to pay-for-value should be supported and hastened. Collaboration on—and clarification of—new directives will help build trust between administrators and clinicians.

Patient Trust in Health Care

Patients trust clinicians when the clinician truly hears the patient's concerns and demonstrates that they are acting in the patient's best interest. Time pressure in the clinical setting and unskilled use of electronic tools worsens two-way communication. The ways patients can engage with the health care system have also changed significantly in recent years. Health topics that were not usually talked about in public are frequently discussed openly. Prescription medications are advertised directly to the consumer. Patient portals, virtual visits, and texting all offer benefits of increased engagement with health care providers but are also in their infancy with regard to best practice. Anyone can access information about a health condition online, so many patients go into a clinical encounter well versed in information they have gained outside the clinical setting that may be accurate, skewed, or incorrect. These changes especially affect members of marginalized populations. As data have become more available, variation in clinical experience among marginalized populations is more visible and adds to skepticism about the goodwill of clinicians and the health care system [13, 14].

that paid to Recommendation 5.3 cited here [1]. Cross-cultural education focuses on attitudes, knowledge, and skills to enhance health professionals' awareness of how cultural and social factors influence health care, while providing methods to obtain, negotiate, and manage this information clinically once it is obtained.

It seems appropriate to end with a quote taken from the first-ever scientific paper written on the subject of racial concordance: "In the meantime, by reducing the number of underrepresented minorities entering the US workforce, the reversal of affirmative action policies may adversely affect the delivery of health care to Black and Hispanic Americans" [3]. NCMJ

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Patients feel the changes in the system, especially when they do not understand them. As Lee and colleagues note:

> "Organizations are merging, creating new structures, and adopting new names in place of those known to patients for decades, leading to the loss of familiar brands with trusted reputations. The merging process can also lead to changes in tangible and intangible aspects of the care experience that leave patients feeling like they have changed clinicians even when they are seeing the same clinicians but in a setting that looks, feels, and acts differently" [15].

To improve patient trust, clinicians need to take the time to listen and engage with their patients to determine and carry out the appropriate care plan. More needs to be learned about the best ways to utilize the EHR and other virtual tools, and both patients and clinicians will need to adopt best practices. The health care system and clinicians need to focus on understanding and meeting the needs of racial minorities and marginalized populations, since trust is most often lacking in these groups of patients [14]. Systems need to ensure that patients understand the structure of new and merged systems and should function in ways that demonstrate the benefit of these new constructs to the patient.

Patients need to be empowered to find the best information available and develop skills to differentiate good information from bad. Clinicians should recognize that while they may have a knowledge advantage about a clinical condition, the patient has the knowledge advantage about the patient's own experience. Patients and clinicians need to improve two-way conversations about concerns and plans.

Addressing Stress

Stress among the workforce in the clinical setting has increased dramatically due to organizational mergers, inadequate staffing, tight clinical schedules, performance targets, and burdens arising from the EHR. Chaos in a clinical setting—including diminished control and bottlenecks in clinic flow—leads to lower job satisfaction, decreased teamwork and professionalism, more stress, and a higher likelihood of leaving the practice within two years. Chaotic clinics also have higher rates of medical errors and missed opportunities for preventive care [16, 17].

Too much stress has a serious negative impact on trust. Clinicians should have an opportunity to fully understand new administrative constructs and requirements. Clinical