The Social and Moral Determinants of Health

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Medicine's social contract

Established by licensing laws in the mid-19th century, society granted physicians a monopoly over the use of medicine's knowledge base, autonomy in practice, status, and the privilege of self-regulation

Based on the understanding the profession would assure the competence of its members, who would be devoted to altruistic service, demonstrate morality and integrity in all of their activities, and address issues of societal concern in their domain.

Based on professionalism. Fundamental to this relationship is trust. Society must trust individual physicians and physicians must believe society will meet its reasonable expectations.

TABLE 1. Social Contract between Medicine and Society

Society's Expectations of Medicine	Medicine's Expectations of Society
• Services of the healer	• Trust
• Assured competence	• Autonomy
• Altruistic service	• Self-regulation
• Morality and integrity	• Health care system value-driven adequately funded
• Accountability	• Participation in public policy
• Transparency	• Shared (patients and society) responsibility for health
• Source of objective advice	• Monopoly
• Promotion of the public good	• Status and rewards – non-financial • respect • status – financial

Cruess, S.R., 2006. Professionalism and medicine's social contract with society. *Clinical Orthopaedics and Related Research (1976-2007)*, *449*, pp.170-176.

2020 wasn't that long ago

VIEWPOINT

COVID-19 and African Americans

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Related article page 1905

Much has been published in leading medical journals about the phenomenon of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection. The resulting condition, coronavirus disease 2019 (COVID-19), has had a societal effect comparable only to the Spanish flu epidemic of 1918. As the flow of clinical science has better informed the contemporary narratives, more is being learned about which individuals and groups experience the most dire complications. Researchers have emphasized older age, male sex, hypertension, diabetes, obesity, concomitant cardiovascular diseases (including coronary artery disease and heart failure), and myocardial injury as important risk factors associated with worse outcomes; specifically, case-fatality rates vary over 100%.[1-3] These data sourced from China and Europe have not been replicated in the US, but the US experience may nevertheless represent similarly distressing outcomes in these highest-risk phenotypes.

The concerns about these observations are appropriate and the published data are indeed actionable; those who fit the highest-risk phenotypes can be advised to assiduously adhere to safe practices including hand hygiene, use of masks in public spaces, and social distancing/physical isolation.[4] These measures not only are flattening the curve but are no doubt saving lives. However, a new concern has arisen: evidence of potentially egregious health care disparities is now apparent. Persons who are African American or black are contracting SARS-CoV-2 at higher rates and are more likely to die.[5]

> The US has needed a trigger to fully address health care disparities; COVID-19 may be that bellwether event.

Why is this uniquely important to me? I am an academic cardiologist; I study health care disparities; and I am a black man.

What is currently known about these differences in disease risk and fatality rates? In Chicago, more than 50% of COVID-19 cases and nearly 70% of COVID-19 deaths involve black individuals, although blacks make up only 30% of the population. Moreover, these deaths are concentrated mostly in just 5 neighborhoods on the city's South Side.[6] In Louisiana, 70.5% of deaths have occurred among black persons, who represent 32.2% of the state's population.[7] In Michigan, 33% of COVID-19 cases and 40% of deaths have occurred among black individuals, who represent 14% of the population.[5] If New York City has become the epicenter, this disproportionate burden is validated again in underrepresented minorities, especially blacks and now Hispanics, who have accounted for 28% and 34% of deaths, respectively (population representation: 22% and 29%, respectively).[8]

The Johns Hopkins University and American Community Survey indicate that to date, of 131 predominantly black counties in the US, the infection rate is 137.5/100 000 and the death rate is 6.3/100 000.[5] This infection rate is more than 3-fold higher than that in predominantly white counties. Moreover, this death rate for predominantly black counties is 6-fold higher than in predominantly white counties. Even though these data are preliminary and further study is warranted, the pattern is irrefutable: underrepresented minorities are developing COVID-19 infection more frequently and dying disproportionately. Do these observations qualify as evident health care disparities?

Yes. The definition of a health care disparity is not simply a difference in health outcomes by race or ethnicity, but a disproportionate difference attributable to variables other than access to care.[9] Given the known risk factors for COVID-19 complications, the confluence of hypertension, diabetes, obesity, and the higher prevalence of cardiovascular disease among black persons may be driving these early signals. Data fully adjusted for comorbidities have not been reported but it is likely that some, if not most, of these differences in disease rates and outcomes will be explained by concomitant comorbidities.

But concerns go beyond these comorbidities. Where and how black individuals live matters. If race per se enters this discussion, it is because in so many communities, race determines home. Once adverse outcomes attributable to known risks for COVID-19 complications are disaggregated from total morbidity and mortality burden due to COVID-19, the pernicious influence of adverse social determinants of health is likely to become apparent.[10] The communities where many black people reside are in poor areas characterized by high housing density, high crime rates, and poor access to healthy foods. Low socioeconomic status alone is a risk factor for total mortality independent of any other risk factors. These social determinants of health must be considered in a complex equation, including known cardiovascular risk factors, which puts underrepresented minorities who live in at-risk communities at greater risk for disease, not just for cardiovascular diseases but now for COVID-19 mortality.

The most effective strategy known to reduce COVID-19 infection is social distancing, but herein lies a vexing challenge. Being able to maintain social distancing while working from home, telecommuting, and accepting a furlough from work but indulging in the plethora of virtual social events are issues of *privilege*. In certain communities these privileges are simply not accessible. Thus, consider the aggregate of a higher burden of at-risk comorbidities, the pernicious effects of adverse social determinants of health, and the

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EDITORIAL

COVID-19 and Health Equity—A New Kind of "Herd Immunity"

David R. Williams, PhD, MPH; Lisa A. Cooper, MD, MPH

Viewpoint page 2466

Three articles recently published in *JAMA* provide insight into the large racial/ethnic differences associated with coronavirus disease 2019 (COVID-19) and highlight the need for, and potential opportunity to, redouble efforts in the US to develop strategies that would enable society to slow and ultimately eliminate the spread of inequities in health.[1-3] COVID-19 is a magnifying glass that has highlighted the larger pandemic of racial/ethnic disparities in health. For more than 100 years research has documented that African American and Native American individuals have shorter life spans and more illness than white persons. Hispanic immigrants initially tend to have a relatively healthy profile but with increasing length of stay in the US, their health tends to decline. A black infant born in the US is more than twice as likely to die before his or her first birthday compared with a white infant. In adulthood, black individuals have higher death rates than white persons for most of the leading causes of death.

Health Care Access and Quality Matter

Owen and colleagues[1] provide a poignant example of systemic inequities in health care. Compared with white individuals, African American individuals have higher rates of uninsurance and underinsurance. Segregation of health care also contributes to racial disparities in health care with access to primary care and especially specialty care physicians more limited in communities of color. COVID-19 testing centers are more likely to be in well-off suburbs of predominantly white residents than in low-income neighborhoods that are predominantly black. The advice to obtain testing through a primary care clinician limits access to testing for people who lack one.

One way that racism adversely affects minorities is through the negative beliefs and stereotypes about race that are embedded in US culture. Studies from 2015 and 2017 reported that the majority of health care clinicians had implicit biases against African American individuals and that bias in the clinical encounter was associated with poorer patient-clinician communication and quality of care.[4,5] A recent report based on billing data for COVID-19 testing from several states revealed that African American patients with symptoms such as cough and fever were less likely than white individuals with the same symptoms to be given a test.[6] Health care workers are heroes because they care for patients affected by this pandemic, but they are also human, working under stressful conditions that increase the risk of biased behavior. Improving access to care for all and ensuring high-quality care, with greater focus on underresourced settings and vulnerable groups, is an important "treatment" for racial disparities in health.

Beyond Medical Care

However, medical care alone will not pr
"herd immunity" to racial/ethnic inequitie
and colleagues[1] indicate that the main c
long-term pathogenic effects of exposure
and working conditions. The analyses
colleagues[2] provide further insight. The a
risks linked to COVID-19 varied markedly b
dence in New York City. The Bronx had th
income and education and the highest pr
and Hispanic persons. Although the Bron
rate of COVID-19 tests performed, it also ha
of COVID-19 hospitalizations and dea
Manhattan, the predominantly white, mos
of New York City, had the lowest rates of hc
death related to COVID-19, although it had
lation density. Similarly, the Viewpoint by
the disproportionate death rates for black p
were concentrated in 4 neighborhoods.

These data highlight that social inequi
by place, and opportunities to be healthy va
neighborhood level. A clue to understand
these differences is the 2010 Census finding
City area was the second most segregated
in the US, behind Milwaukee and ahead of
and Cleveland.[7] An estimated 78% of Afric
dents in New York City would have to reloca
distribution of black and white population
segregation is not residing among persons
but the clustering of social disadvantage a
investment in marginalized communities.

Residential segregation by race/ethnic
preciated driver of inequality in the US. Alth
has been illegal since the 1960s, it is perpe
interlocking set of individual actions, insti
and governmental policies. Reported rece
regation have not altered the residential con
lation of most African American populatior
In addition, although most immigrant groups have experienced residential segregation in the US, no immigrant group has lived under the high levels of segregation that have existed for black people for more than a century.

Segregation is a critical determinant of economic status, which is a strong predictor of variations in health. In 2018, for every dollar of household income that white workers earned, black workers earned 59 cents and Hispanic workers, 72 cents.[8] This figure for black workers is identical to the black-white gap in income in 1978–the peak year of the economic gains for black individuals due to the antipoverty and Civil Rights policies of

VIEWPOINT

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Viewpoint pages 227, 229, 231, and Editorial page 245

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The Moral Determinants of Health

The source of what the philosopher Immanuel Kant called "the moral law within" may be mysterious, but its role in the social order is not. In any nation short of dictatorship some form of moral compact, implicit or explicit, should be the basis of a just society. Without a common sense of what is "right," groups fracture and the fragments wander. Science and knowledge can guide action; they do not cause action.

No scientific doubt exists that, mostly, circumstances outside health care nurture or impair health. Except for a few clinical preventive services, most hospitals and physician offices are repair shops, trying to correct the damage of causes collectively denoted "social determinants of health." Marmot[1] has summarized these in 6 categories: conditions of birth and early childhood, education, work, the social circumstances of elders, a collection of elements of community resilience (such as transportation, housing, security, and a sense of community self-efficacy), and, cross-cutting all, what he calls "fairness," which generally amounts to a sufficient redistribution of wealth and income to ensure social and economic security and basic equity. Galea[2] has cataloged social determinants at a somewhat finer grain, calling out, for example, gun violence, loneliness, environmental toxins, and a dozen more causes.

> When the fabric of communities upon which health depends is torn, then healers are called to mend it. The moral law within insists so.

The power of these societal factors is enormous compared with the power of health care to counteract them. One common metaphor for social and health disparities is the "subway map" view of life expectancy, showing the expected life span of people who reside in the neighborhood of a train or subway stop. From midtown Manhattan to the South Bronx in New York City, life expectancy declines by 10 years: 6 months for every minute on the subway. Between the Chicago Loop and west side of the city, the difference in life expectancy is 16 years. At a population level, no existing or conceivable medical intervention comes within an order of magnitude of the effect of place on health. Marmot also estimated if the population were free of heart disease, human life expectancy would increase by 4 years,[1] barely 25% of the effect associated with living in the richer parts of Chicago instead of the poorer ones.

How do humans invest in their own vitality and longevity? The answer seems illogical. In wealthy nations, science points to social causes, but most economic investments are nowhere near those causes. Vast, expensive repair shops (such as medical centers and emergency services) are hard at work, but minimal facilities are available to prevent the damage. In the US at the moment, 40 million people are hungry, almost 600 000 are homeless, 2.3 million are in prisons and jails with minimal health services (70% of whom experience mental illness or substance abuse), 40 million live in poverty, 40% of elders live in loneliness, and public transport in cities is decaying. Today, everywhere, as the murder of George Floyd and the subsequent protests make clear yet again, deep structural racism continues its chronic, destructive work. In recent weeks, people in their streets across the US, many moved perhaps by the "moral law within," have been protesting against vast, cruel, and seemingly endless racial prejudice and inequality.

Decades of research on the true causes of ill health, a long series of pedigreed reports, and voices of public health advocacy have not changed this underinvestment in actual human well-being. Two possible sources of funds seem logically possible: either (a) raise taxes to allow governments to improve social determinants, or (b) shift some substantial fraction of health expenditures from an overbuilt, high-priced, wasteful, and frankly confiscatory system of hospitals and specialty care toward addressing social determinants instead. Either is logically possible, but neither is politically possible, at least not so far.

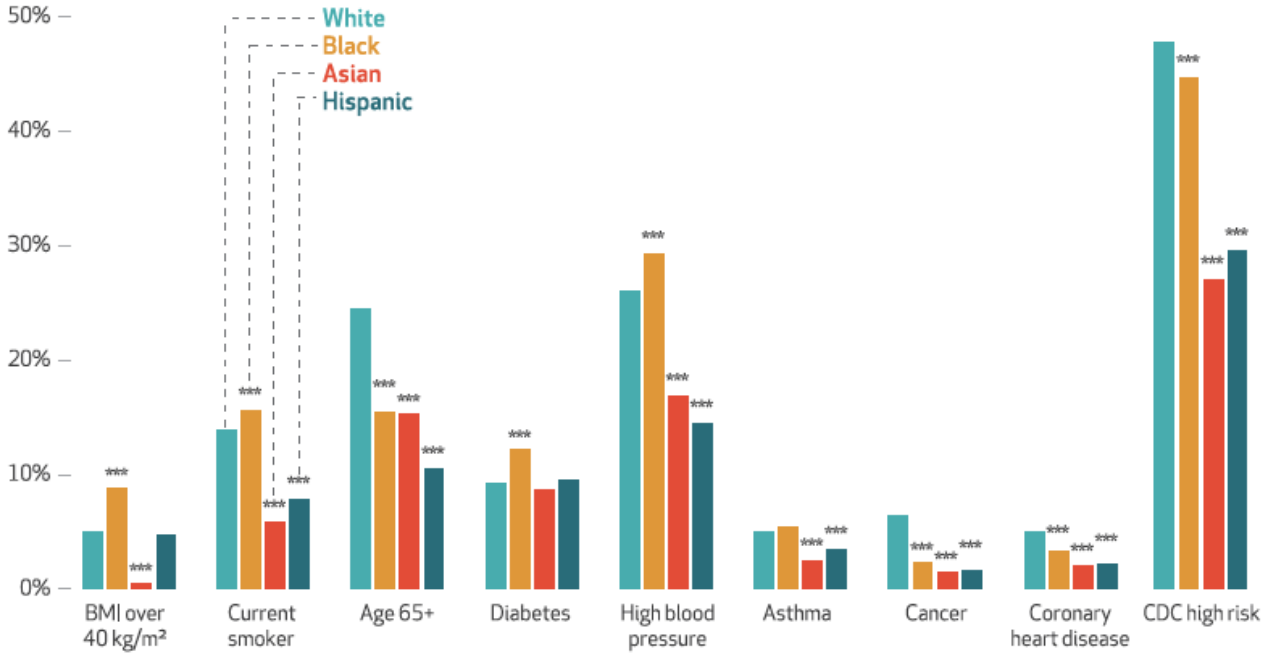
Neither will happen unless and until an attack on racism and other social determinants of health is motivated by an embrace of the moral determinants of health, including, most crucially, a strong sense of social solidarity in the US. "Solidarity" would mean that individuals in the US legitimately and properly can depend on each other for helping to secure the basic circumstances of healthy lives, no less than they depend legitimately on each other to secure the nation's defense. If that were the moral imperative, government—the primary expression of shared responsibility—would defend and improve health just as energetically as it defends territorial integrity.

Imagine, for a moment, that the moral law within commanded shared endeavor for securing the health of communities. Imagine, further, that the healing professions together saw themselves as bearers of that news and leaders of that change. What would the physicians, nurses, and institutions of US health care insist on and help lead, as an agenda for action? A short list follows, the first-order elements of a morally guided campaign for better health.

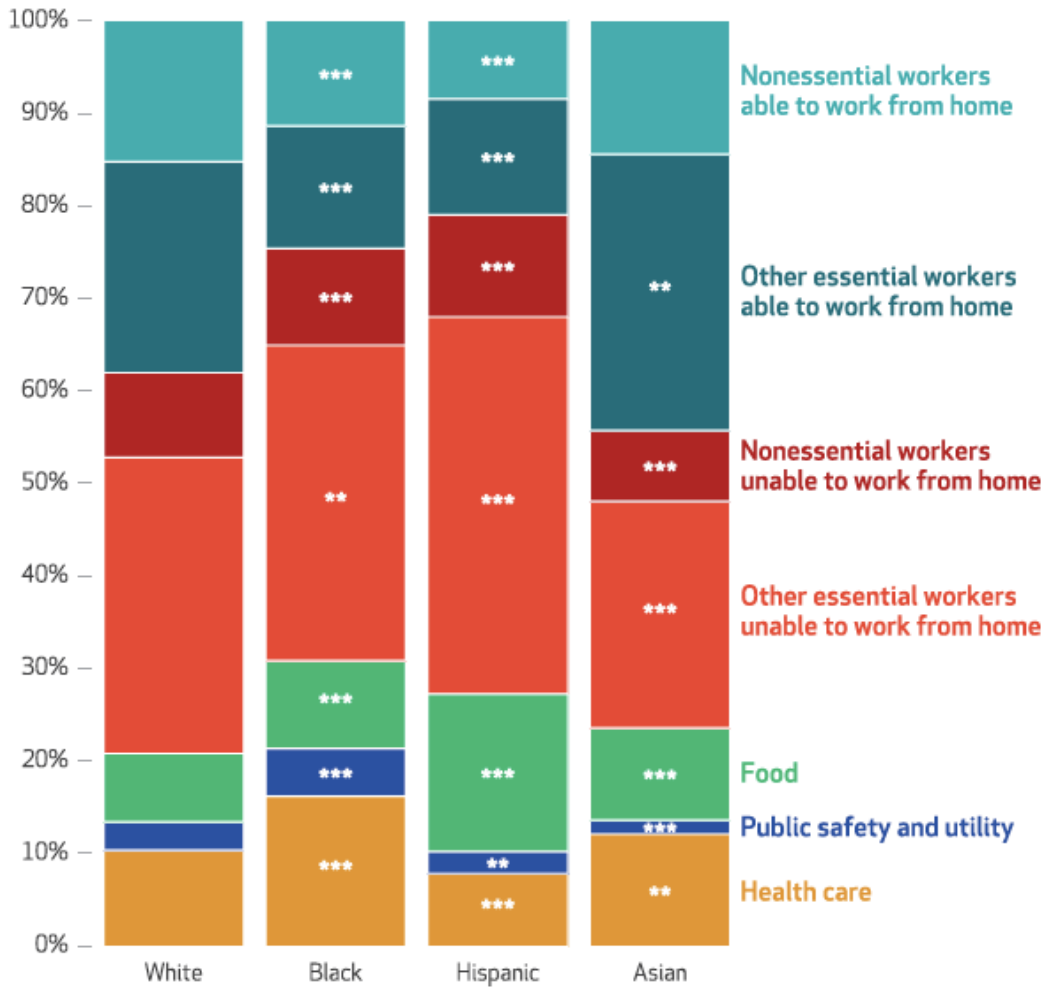
- US ratification of the basic human rights treaties and conventions of the international community. The US, alone among western democracies, has not ratified a long list of basic United Nations agreements on human rights, including the International Covenant on

Covid-19's disproportionate impact on minoritized individuals

Prevalence among US adults of selected risk factors and an overall Centers for Disease Control and Prevention (CDC) indicator for being at high risk for severe COVID-2019 illness, by race and ethnicity, 2014–17



Job characteristics among US workers, by race and ethnicity, 2014–17



TM Selden and TA Berdahl Health Affairs 39,NO. 9 (2020): 1624–1632


SILENCE
IS
VIOLENCE


DEFUND
NYPD


COVID
IS A
PANDEMIC
POLICE BRUTALITY
IS AN
EPIDEMIC
#BLM

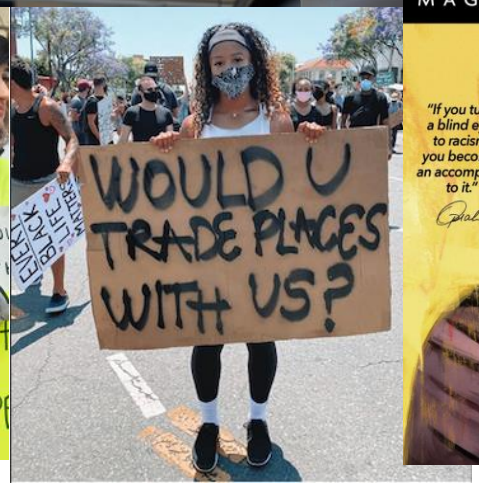

MILITARY
POLICE
MILITARY
POLICE


Justice
for
Breonna
Taylor
facebook.com/mikeramosbrigade


O
THE OPR
MAGAZ
Breonna
Taylor
Born June 5 1993
Killed by police
March 13 2020
HER LIFE
MATTERS
"If you turn
a blind eye
to racism,
you become
an accomplice
to it."


SPEED
LIMIT


KEEP
CALM
AND
DON'T SHOOT
BLACK PEOPLE
WHITE COATS
4
BLACK LIVES
I CAN'T BREATHE


WOULD U
TRADE PLACES
WITH US?

Moral determinants of health

The source of what the philosopher Immanuel Kant called “the moral law within” may be mysterious, but its role in the social order is not. In any nation short of dictatorship some form of moral compact, implicit or explicit, should be the basis of a just society. Without a common sense of what is “right,” groups fracture and the fragments wander. Science and knowledge can guide action; they do not cause action.

He makes the argument that the murder of George Floyd and the subsequent protests make clear yet again, deep structural racism continues its chronic, destructive work. In recent weeks, people in their streets across the US, many moved perhaps by the “moral law within,” have been protesting against vast, cruel, and seemingly endless racial prejudice and inequality.

Opinion

VIEWPOINT

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Viewpoint pages 227, 229, 231, and Editorial page 245

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Neither will happen unless and until an attack on racism and other social determinants of health is motivated by an embrace of the moral determinants of health, including, most crucially, a strong sense of social solidarity in the US. "Solidarity" would mean that individuals in the US legitimately and properly can depend on each other for helping to secure the basic circumstances of healthy lives, no less than they depend legitimately on each other to secure the nation's defense. If that were the moral imperative, government—the primary expression of shared responsibility—would defend and improve health just as energetically as it defends territorial integrity.

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Berwick, D.M., 2020. The moral determinants of health. *Jama*, *324*(3), pp.225-226.

Social determinants of health

Marmot has summarized these in 6 categories:

1) Conditions of birth and early childhood
2) Education
3) Work
4) Social circumstances of elders
5) A collection of elements of community resilience (such as transportation, housing, security, and a sense of community self-efficacy)
6) Fairness (Generally amounts to a sufficient redistribution of wealth and income to ensure social and economic security and basic equity)

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Marmot M. The Health Gap: The Challenge of an Unequal World. Bloomsbury; 2015.

Galea S.Well: What We Need to Talk About When We Talk About Health. Oxford University Press; 2019

An underinvestment in actual human well-being

Berwick offered two possible solutions:

Raise taxes to allow governments to improve social determinants, or

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Berwick's imagination

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1) US ratification of the basic human rights treaties and conventions of the international community
2) Realization in statute of health care as a human right in the US.
3) Restoring US leadership to reverse climate change
4) Achieving radical reform of the US criminal justice system, eliminating mass incarceration
5) Ending policies of exclusion and achieving compassionate immigration reform
6) Ending hunger and homelessness in the US
7) Restoring order, dignity, and equity to US democratic institutions and ensuring the right of every single person's vote to count equally

Berwick, D.M., 2020. The moral determinants of health. *Jama*, *324*(3), pp.225-226.

What does this look like for the healers?

Physicians, nurses, and other health care professionals can speak out, write opinion pieces, work with community organizations devoted to the issues listed, and, most important of all, vote and ensure that colleagues vote on election days

Organizations can also act: they can contact local criminal justice authorities and develop programs to ensure proper care for incarcerated people and create paths of reentry to work and society for people leaving incarceration

Identify needs for housing and food security in local communities, set goals for improvement, and manage progress as for any health improvement project.

Pay all staff wages sufficient for healthy living, which is far above legal minimum wages.

They can lobby harder for universal health insurance coverage and US participation in human rights conventions than for the usual agendas of better reimbursement and regulatory relief.

They can examine and work against implicit and structural racism. They can do whatever it takes to ensure universal voter turnout for the entire health care workforce.

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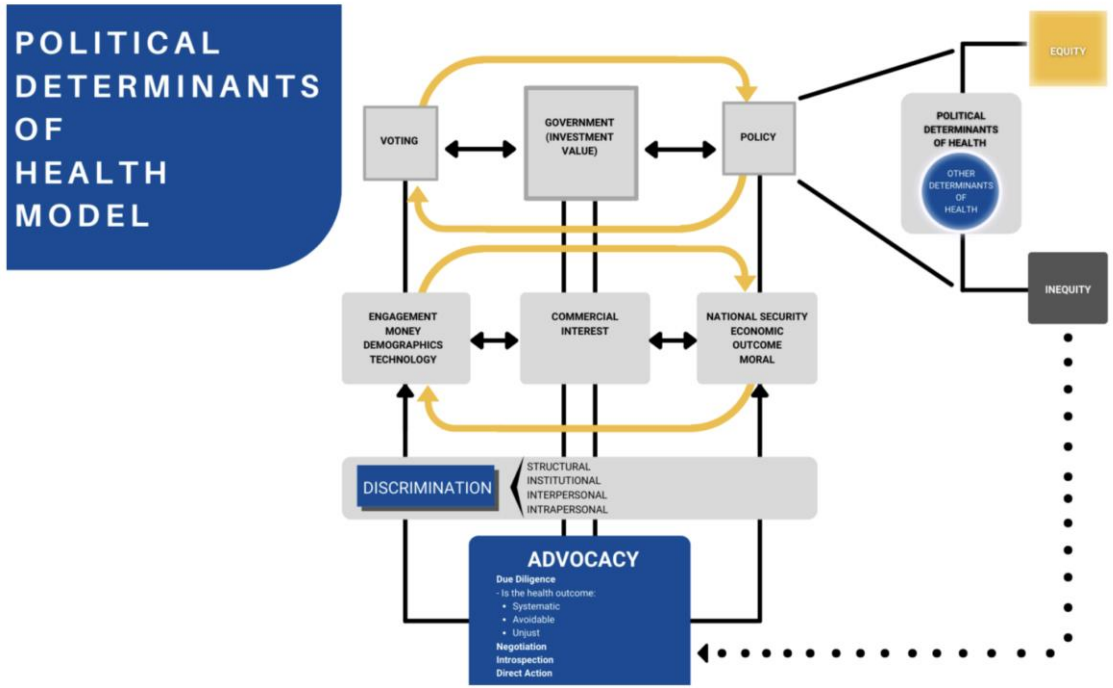
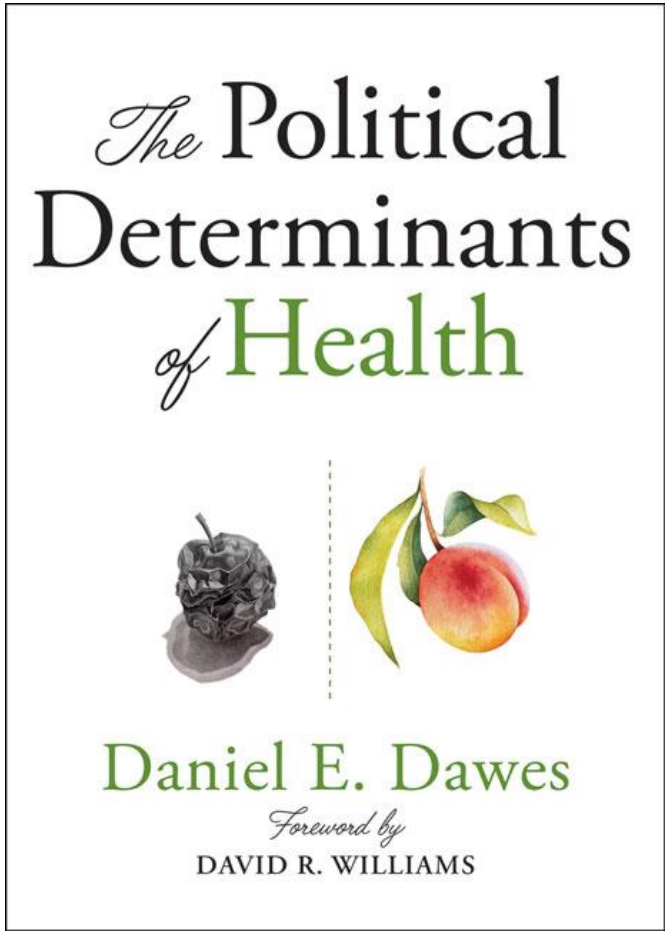
The political determinants of health

The political determinants of health recognize how inequitable policies, politics, regulations, and laws have impaired access to care and contribute to health inequities

Speaks to the outsized voice that physicians have to drive societal change





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

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ACGME has initiated a sponsoring institution fellowship in correctional (carceral)medicine.

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https://www.acgme.org/globalassets/pfassets/proposalreviewandcomment/corrmedproposal.pdf

Power of the moral determinants of health to heal

To many US physicians and nurses who trained for, are committed to, and are experienced in addressing health problems in individual patients, this campaign list may seem out of character. However, if the moral law within dictated that the shared goal was health, and if logic counseled that science should be the guide to investment, and that the endeavor must be communal, not just individual, then the list above would be a clear and rational to-do list to get started on well-being.

Healers are called to heal. When the fabric of communities upon which health depends is torn, then healers are called to mend it. The moral law within insists so. Improving the social determinants of health will be brought at last to a boil only by the heat of the moral determinants of health,

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Was COVID-19 enough?

Public health is complicated and social reengineering is complex but change of this magnitude does not happen without a new resolve. The US has needed a trigger to fully address health care disparities; COVID-19 may be that bellwether event. Certainly, within the broad and powerful economic and legislative engines of the US, there is room to definitively address a scourge even worse than COVID-19: health care disparities. It only takes will. It is time to end the refrain.

This is a moment for ethical reckoning and it calls for new resolve.

Opinion

VIEWPOINT

COVID-19 and African Americans

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Related article page 1905

Much has been published in leading medical journals about the phenomenon of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection. The resulting condition, coronavirus disease 2019 (COVID-19), has had a societal effect comparable only to the Spanish flu epidemic of 1918. As the flow of clinical science has better informed the contemporary narratives, more is being learned about which individuals and groups experience the most dire complications. Researchers have emphasized older age, male sex, hypertension, diabetes, obesity, concomitant cardiovascular diseases (including coronary artery disease and heart failure), and myocardial injury as important risk factors associated with worse outcomes; specifically, case-fatality rates vary over 100%.[1-3] These data sourced from China and Europe have not been replicated in the US, but the US experience may nevertheless represent similarly distressing outcomes in these highest-risk phenotypes.

The concerns about these observations are appropriate and the published data are indeed actionable; those who fit the highest-risk phenotypes can be advised to assiduously adhere to safe practices including hand hygiene, use of masks in public spaces, and social distancing/physical isolation.[4] These measures not only are flattening the curve but are no doubt saving lives. However, a new concern has arisen: evidence of potentially egregious health care disparities is now apparent. Persons who are African American or black are contracting SARS-CoV-2 at higher rates and are more likely to die.[5]

> The US has needed a trigger to fully address health care disparities; COVID-19 may be that bellwether event.

Why is this uniquely important to me? I am an academic cardiologist; I study health care disparities; and I am a black man.

What is currently known about these differences in disease risk and fatality rates? In Chicago, more than 50% of COVID-19 cases and nearly 70% of COVID-19 deaths involve black individuals, although blacks make up only 30% of the population. Moreover, these deaths are concentrated mostly in just 5 neighborhoods on the city's South Side.[6] In Louisiana, 70.5% of deaths have occurred among black persons, who represent 32.2% of the state's population.[7] In Michigan, 33% of COVID-19 cases and 40% of deaths have occurred among black individuals, who represent 14% of the population.[5] If New York City has become the epicenter, this disproportionate burden is validated again in underrepresented minorities, especially blacks and now Hispanics, who have accounted for 28% and 34% of deaths, respectively (population representation: 22% and 29%, respectively).[8]

The Johns Hopkins University and American Community Survey indicate that to date, of 131 predominantly black counties in the US, the infection rate is 137.5/100 000 and the death rate is 6.3/100 000.[5] This infection rate is more than 3-fold higher than that in predominantly white counties. Moreover, this death rate for predominantly black counties is 6-fold higher than in predominantly white counties. Even though these data are preliminary and further study is warranted, the pattern is irrefutable: underrepresented minorities are developing COVID-19 infection more frequently and dying disproportionately. Do these observations qualify as evident health care disparities?

Yes. The definition of a health care disparity is not simply a difference in health outcomes by race or ethnicity, but a disproportionate difference attributable to variables other than access to care.[9] Given the known risk factors for COVID-19 complications, the confluence of hypertension, diabetes, obesity, and the higher prevalence of cardiovascular disease among black persons may be driving these early signals. Data fully adjusted for comorbidities have not been reported but it is likely that some, if not most, of these differences in disease rates and outcomes will be explained by concomitant comorbidities.

But concerns go beyond these comorbidities. Where and how black individuals live matters. If race per se enters this discussion, it is because in so many communities, race determines home. Once adverse outcomes attributable to known risks for COVID-19 complications are disaggregated from total morbidity and mortality burden due to COVID-19, the pernicious influence of adverse social determinants of health is likely to become apparent.[10] The communities where many black people reside are in poor areas characterized by high housing density, high crime rates, and poor access to healthy foods. Low socioeconomic status alone is a risk factor for total mortality independent of any other risk factors. These social determinants of health must be considered in a complex equation, including known cardiovascular risk factors, which puts underrepresented minorities who live in at-risk communities at greater risk for disease, not just for cardiovascular diseases but now for COVID-19 mortality.

The most effective strategy known to reduce COVID-19 infection is social distancing, but herein lies a vexing challenge. Being able to maintain social distancing while working from home, telecommuting, and accepting a furlough from work but indulging in the plethora of virtual social events are issues of *privilege*. In certain communities these privileges are simply not accessible. Thus, consider the aggregate of a higher burden of at-risk comorbidities, the pernicious effects of adverse social determinants of health, and the

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Yancy, C.W., 2020. COVID-19 and african americans. *Jama*, *323*(19), pp.1891-1892.

Health equity and racism

Racism adversely affects minorities through the negative beliefs and stereotypes about race that are embedded in US culture.

Residential segregation by race/ethnicity is an underappreciated driver of inequality in the US. It is perpetuated through an interlocking set of individual actions, institutional practices, and governmental policies.

Segregation is a critical determinant of economic status, which is a strong predictor of variations in health. The White-Black, White-Hispanic wealth gap in nearly 10:1

Opinion

EDITORIAL

COVID-19 and Health Equity—A New Kind of "Herd Immunity"

David R. Williams, PhD, MPH; Lisa A. Cooper, MD, MPH

Three articles recently published in *JAMA* provide insight into the large racial/ethnic differences associated with coronavirus disease 2019 (COVID-19) and highlight the need for, and potential opportunity to, redouble efforts in the US to develop strategies that would enable society to slow and ultimately eliminate the spread of inequities in health.[1-3] COVID-19 is a magnifying glass that has highlighted the larger pandemic of racial/ethnic disparities in health. For more than 100 years research has documented that African American and Native American individuals have shorter life spans and more illness than white persons. Hispanic immigrants initially tend to have a relatively healthy profile but with increasing length of stay in the US, their health tends to decline. A black infant born in the US is more than twice as likely to die before his or her first birthday compared with a white infant. In adulthood, black individuals have higher death rates than white persons for most of the leading causes of death.

Viewpoint page 2466

Health Care Access and Quality Matter

Owen and colleagues[1] provide a poignant example of systemic inequities in health care. Compared with white individuals, African American individuals have higher rates of uninsurance and underinsurance. Segregation of health care also contributes to racial disparities in health care with access to primary care and especially specialty care physicians more limited in communities of color. COVID-19 testing centers are more likely to be in well-off suburbs of predominantly white residents than in low-income neighborhoods that are predominantly black. The advice to obtain testing through a primary care clinician limits access to testing for people who lack one.

One way that racism adversely affects minorities is through the negative beliefs and stereotypes about race that are embedded in US culture. Studies from 2015 and 2017 reported that the majority of health care clinicians had implicit biases against African American individuals and that bias in the clinical encounter was associated with poorer patient-clinician communication and quality of care.[4,5] A recent report based on billing data for COVID-19 testing from several states revealed that African American patients with symptoms such as cough and fever were less likely than white individuals with the same symptoms to be given a test.[6] Health care workers are heroes because they care for patients affected by this pandemic, but they are also human, working under stressful conditions that increase the risk of biased behavior. Improving access to care for all and ensuring high-quality care, with greater focus on underresourced settings and vulnerable groups, is an important "treatment" for racial disparities in health.

Beyond Medical Care

However, medical care alone will not provide the needed "herd immunity" to racial/ethnic inequities in health. Owen and colleagues[1] indicate that the main contributor is the long-term pathogenic effects of exposure to adverse living and working conditions. The analyses by Wadhera and colleagues[2] provide further insight. The authors show that risks linked to COVID-19 varied markedly by borough of residence in New York City. The Bronx had the lowest levels of income and education and the highest proportion of black and Hispanic persons. Although the Bronx had the highest rate of COVID-19 tests performed, it also had the highest rate of COVID-19 hospitalizations and deaths. In contrast, Manhattan, the predominantly white, most affluent borough of New York City, had the lowest rates of hospitalizations and death related to COVID-19, although it had the highest population density. Similarly, the Viewpoint by Yancy[3] notes that the disproportionate death rates for black persons in Chicago were concentrated in 4 neighborhoods.

These data highlight that social inequities are patterned by place, and opportunities to be healthy vary markedly at the neighborhood level. A clue to understanding the drivers of these differences is the 2010 Census finding that the New York City area was the second most segregated metropolitan area in the US, behind Milwaukee and ahead of Chicago, Detroit, and Cleveland.[7] An estimated 78% of African American residents in New York City would have to relocate to have an even distribution of black and white populations. The problem of segregation is not residing among persons of the same race, but the clustering of social disadvantage and systematic disinvestment in marginalized communities.

Residential segregation by race/ethnicity is an underappreciated driver of inequality in the US. Although segregation has been illegal since the 1960s, it is perpetuated through an interlocking set of individual actions, institutional practices, and governmental policies. Reported recent declines in segregation have not altered the residential concentration and isolation of most African American populations in urban spaces. In addition, although most immigrant groups have experienced residential segregation in the US, no immigrant group has lived under the high levels of segregation that have existed for black people for more than a century.

Segregation is a critical determinant of economic status, which is a strong predictor of variations in health. In 2018, for every dollar of household income that white workers earned, black workers earned 59 cents and Hispanic workers, 72 cents.[8] This figure for black workers is identical to the black-white gap in income in 1978-the peak year of the economic gains for black individuals due to the antipoverty and Civil Rights policies of

Williams, D.R. and Cooper, L.A., 2020. COVID-19 and health equity—a new kind of "herd immunity". *Jama*, *323*(24), pp.2478-2480.

Herd immunity- Immunize against the negative social determinants

Need to raise awareness of the problem of racial/ethnic inequities in health because acknowledgment of a problem is a prerequisite to working to solve it. The majority of US adults are unaware that racial inequities in health exist. Most US residents overestimate the progress the nation has made toward economic equality and underestimate the degree of persistent racial/ethnic economic inequality.

Efforts are needed that explicitly bring clarity to the determinants of racial/ethnic inequities. In 2015, in a survey that included 2695 people, 50% of white respondents reported that discrimination against white people was as large a problem as discrimination against black populations, and 59% of white respondents indicated that the US has made the needed changes to give black persons equal rights

Although most individuals in the US (64% of white persons and 68% of working-class white persons) believe that hard work is no guarantee of success, 50% of white respondents indicated that racial inequities would be eliminated if only black persons tried harder. Additionally, a report from 2012 indicated that consistently since the 1970s, fewer than 1 in 5 white persons have endorsed the view that the government has an obligation to improve living standards for black individuals. Thus, there is little appetite for government and societal action to address racial/ethnic disparities on the part of large segments of the US population.

Systematic efforts are needed to identify how to tell the story of the challenges of racial/ethnic minorities in ways that resonate with the public to build support for political action. Research indicates that there is a racial gap in empathy, in which individuals in the US have empathic responses to members of their own racial/ethnic group but not to members of a different group.

Williams, D.R. and Cooper, L.A., 2020. COVID-19 and health equity—a new kind of "herd immunity". *Jama*, *323*(24), pp.2478-2480.

Empathy gap

We have become comfortable with disparities because they are not our problem

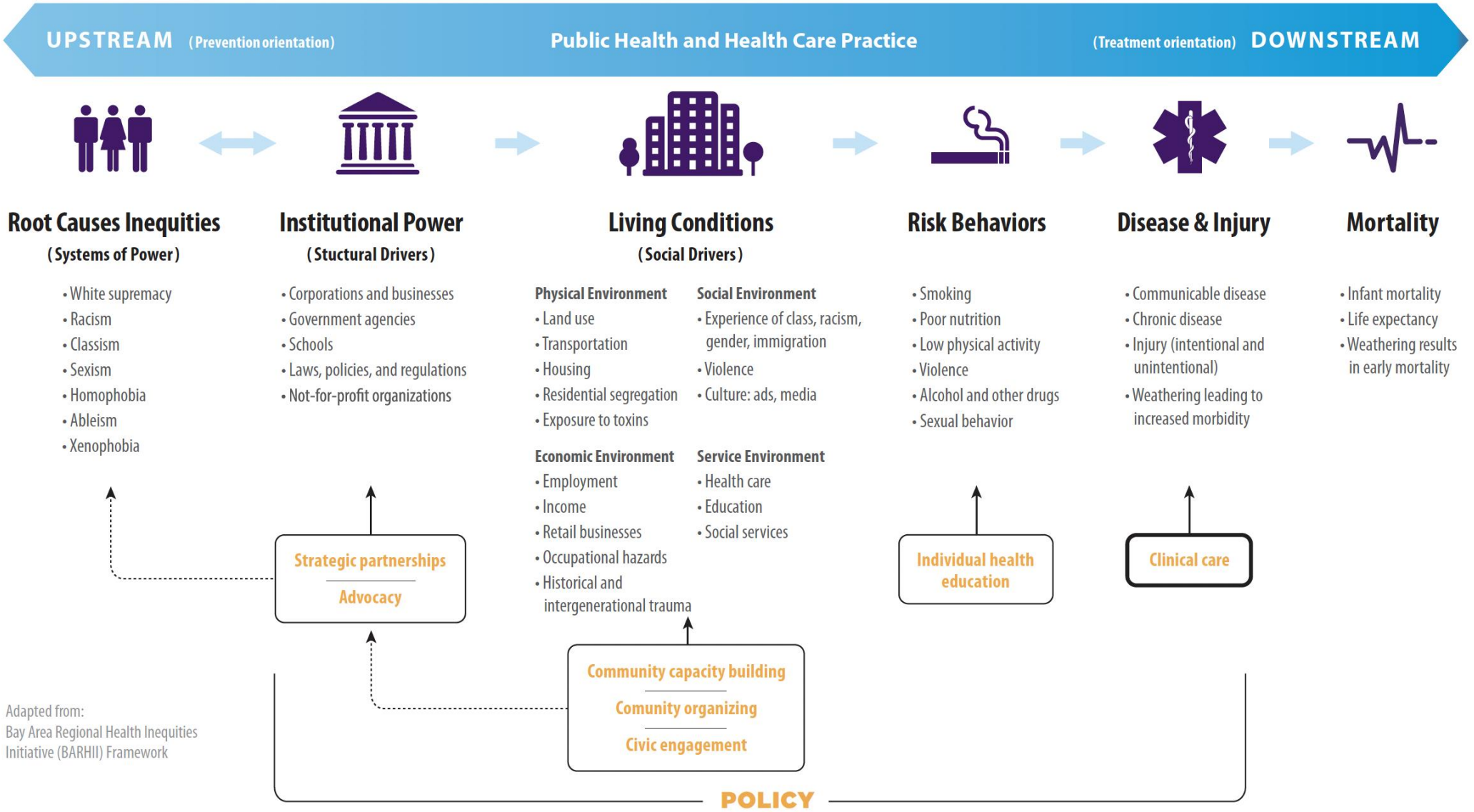
We have become disconnected because we are not proximate to those who are suffering

Vaclav Havel, Czech leader spoke of a willingness of the spirit to sometimes be in hopeless places and be a witness

No one goes to work in healthcare with the idea that they will provide different health care for a patient because they are of a different race, yet lack of empathy creates disparate outcomes

Bryan Stevenson, founder/executive director of the Equal Justice Initiative at AAMC Learn Serve Lead 2019

Figure 3. What Creates Health Framework



American Medical Association. The AMA's strategic plan to embed racial justice and advance health equity. Available at: https://www.ama-assn.org/ about/leadership/ama-s-strategic-plan-embed-racial-justice-and-advancehealth-equity. Published 2021. Accessed October 12, 2023.

ACGME Common Program Requirement II.A.4.a).(2)

The program director must design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program(Core)

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the structural and social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and eliminating health disparities.

ACGME Common Program Requirement IV.B.1.f).

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care(Core)

Background and Intent: Medical practice occurs in the context of an increasingly complex clinical care environment where optimal patient care requires attention to compliance with external and internal administrative and regulatory requirements

Community benefit

In 2008 IRS added a requirement that hospitals submit additional information regarding community benefits on the new Schedule H worksheet attached to their Form 990:

- Unreimbursed costs of charity care
- Participation in means-tested government programs, such as Medicaid
- Health professions education
- Health services research
- Subsidized health services
- Community health improvement activities
- Cash or in-kind contributions to other community groups
- Community building activities, such as investments in housing or environmental improvements

HEALTH POLICY BRIEF WWW.HEALTHAFFAIRS.ORG 1

HealthAffairs | Robert Wood Johnson Foundation

Health Policy Brief

FEBRUARY 25, 2016

Nonprofit Hospitals' Community Benefit Requirements. Under the Affordable Care Act, many nonprofit hospitals must meet new requirements to retain their tax-exempt status.

WHAT'S THE ISSUE?

The majority of hospitals in the United States operate as nonprofit organizations and, as such, are exempt from most federal, state, and local taxes. This favored tax status is intended to be an acknowledgement of the "community benefit" provided by these institutions.

Public controversy over whether nonprofit hospitals provided community benefits sufficient to justify their favored tax status gave rise to congressional scrutiny during 2005–09 and culminated in the inclusion of new community benefit requirements in the Affordable Care Act (ACA). Not only are these new requirements intended to improve transparency and accountability, but they are also part of a strategy to address the ACA priorities of preventive care and population health through community health improvement activities.

WHAT'S THE BACKGROUND?

According to the American Hospital Association (AHA), in 2014 about 78 percent of the 4,974 US community hospitals were nonprofit entities (58 percent private nonprofit and 20 percent operated by state or local governments). The remaining 22 percent are for-profit, investor-owned institutions.

Nonprofit hospitals may qualify for favored tax treatment under federal—as well as a variety of state and local income, property, and sales—tax laws. In addition to tax exemptions, nonprofit status allows hospitals to benefit from tax-exempt bond financing and to receive charitable contributions that are tax-deductible to the donors.

History of federal community benefit requirements

Exemptions from income taxes for charitable institutions date back to the first income tax code enacted in 1913. In 1954 Section 501(c)(3) of the Internal Revenue Code was codified and provided for the exemption from federal income tax for organizations that operated exclusively for religious, charitable, scientific, or educational purposes. Prior to 1969, to qualify for tax-exempt status a hospital had to provide, "to the extent of its financial ability, free or reduced-cost care to patients unable to pay for it." In 1969 this charitable care standard was replaced with a more general requirement that compelled hospitals to engage in activities that benefit the communities they serve. Under the "community benefit" standard, spending that promotes community health, in addition to charity care, counts toward meeting the requirements for tax exemption.

10.1377/hpb2016.3

James, J., 2016. *Nonprofit hospitals' community benefit requirements*. Washington, DC, USA: Project HOPE.

Community needs assessment

Each nonprofit hospital must conduct a community health needs assessment at least once every three years and develop strategies to meet the needs identified in the assessment. Hospitals must seek broad community input, including from public health officials

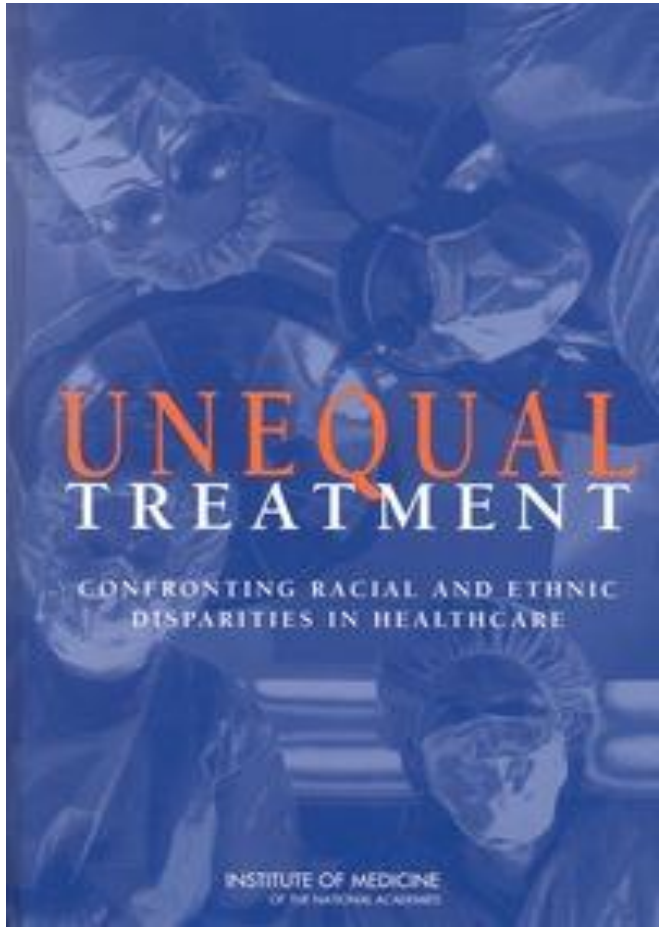
Regulations require that the assessment address not only financial and other barriers to care but also the need to prevent illness; ensure adequate nutrition; and address social, behavioral, and environmental factors that influence the community's health or emergency preparedness.

Hospitals that fail to comply are subject to a $50,000 excise tax penalty. Enforcement is the responsibility of the secretary of the treasury, through the IRS. Noncompliance will result in a revocation of tax-exempt status for the institution

Many states have their own community benefit laws that vary substantially from state to state in scope and detail, including the amount and type of evidence that must be reported, and that may exceed requirements of federal law

James, J., 2016. *Nonprofit hospitals' community benefit requirements*. Washington, DC, USA: Project HOPE.

Evidence of racial and ethnic disparities in healthcare

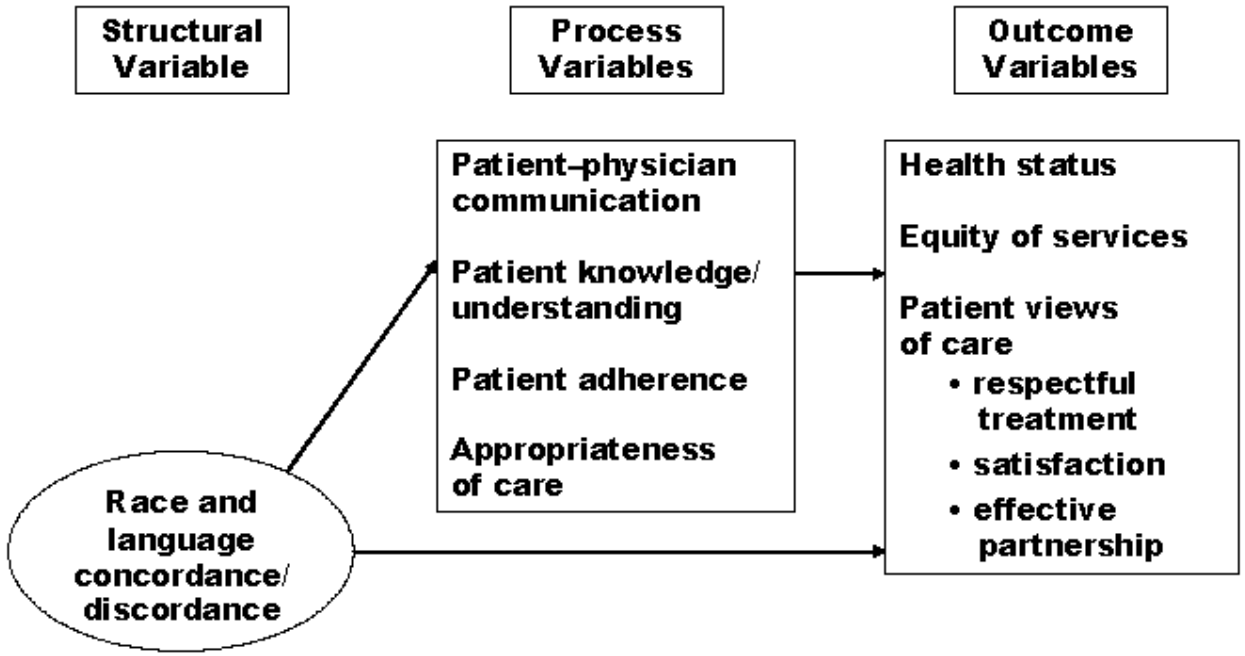


Nat Academy Press 2002
http://www.nap.edu/catalog/10260.html

- 584 pages detailing the extent of racial and ethnic differences in health outcomes that are not otherwise attributable to known factors such as access to health care
- **Disparities consistently found across a wide range of disease areas and clinical services**
- Disparities are found even when clinical factors, such as stage of disease presentation, co-morbidities, age, and severity of disease were adjusted
- Disparities are **found across a range of clinical settings**, including public and private hospitals, teaching and non-teaching hospitals, etc.
- Disparities in care are **associated with higher mortality** among minorities (e.g., Bach et al., 1999; Peterson et al., 1997; Bennett et al., 1995)

IOM Study Recommendations

Figure 1. Does race and/or language concordance between physicians and patients improve processes and outcomes of health care?



Patient education programs should be implemented to increase patients' knowledge of how to best access care and participate in treatment decisions

Integrate cross-cultural education into the training of all current and future health professionals

Increase in the proportion of underrepresented U.S. racial and ethnic minorities among health professionals

Cooper and Powe Commonwealth Fund Report: Disparities In Patient Experiences, Health Care Processes, and Outcomes: The Role of Patient-Provider Racial, Ethnic, and Language Concordance 2004

ACGME Foundational Principles

- Ground the need for diversity in the mission of achieving improvement in health of individuals and population health. As such, elimination of health disparities of marginalized communities is a true north for advancing change
- Workforce diversity has multiple benefits that can be used to benefit the elimination of health and healthcare disparities:
  - Disproportionate tendency for racially concordant patient-physician relationships
  - Improved patient-physician outcomes with concordant relationships
  - Improved patient outcomes through physician advocacy
  - Enhanced research agenda with diverse physicians in academic medicine
  - Increased mentoring for minoritized trainees and students in the learning environment
  - Enhanced capacity to model compassionate care for all to dominant culture colleagues and to ally them in providing physician advocacy for minoritized patients and communities

ACGME foundational principles in DEI

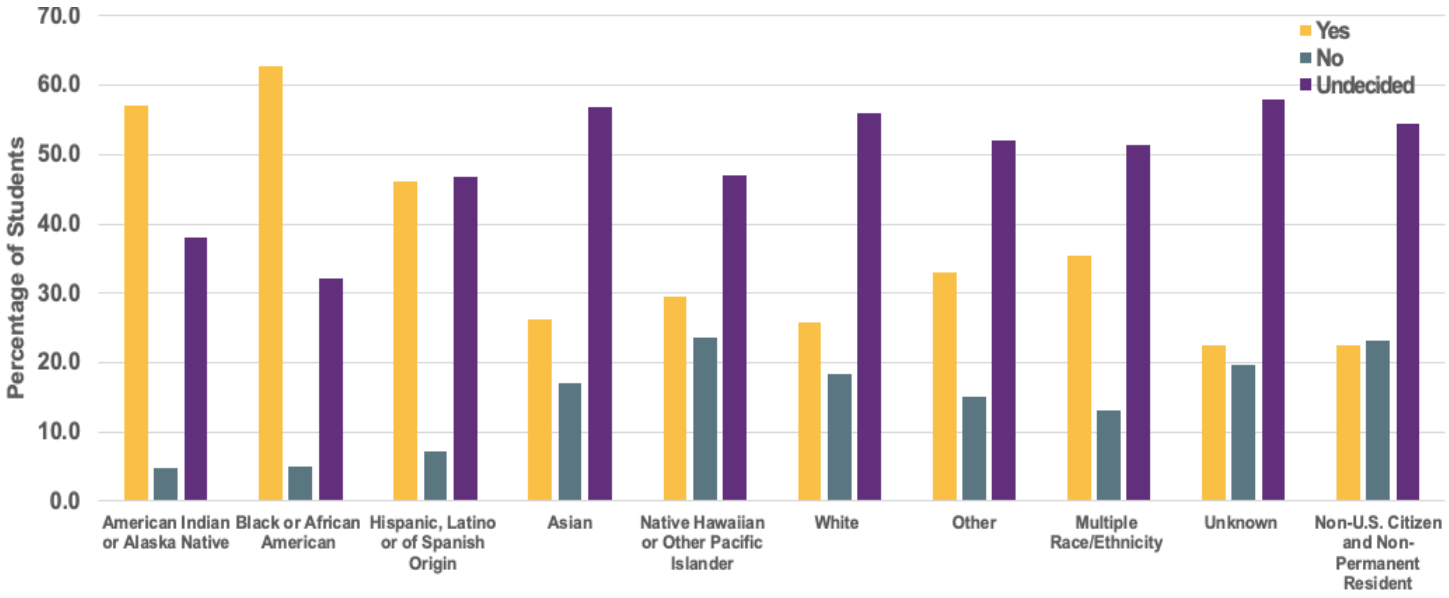
- Society must view healthcare disparities as deficiencies in healthcare quality and medicine must seek to improve quality
- Health equity is a means to achieve elimination of healthcare disparities
- Increasing workforce diversity is a means to achieve health equity
- Inclusion is a tool to ensure that diversity is successful
- Our goal is to advance diversity, equity, and inclusion to improve the care of patients and populations

Why does healthcare worker diversity matter?

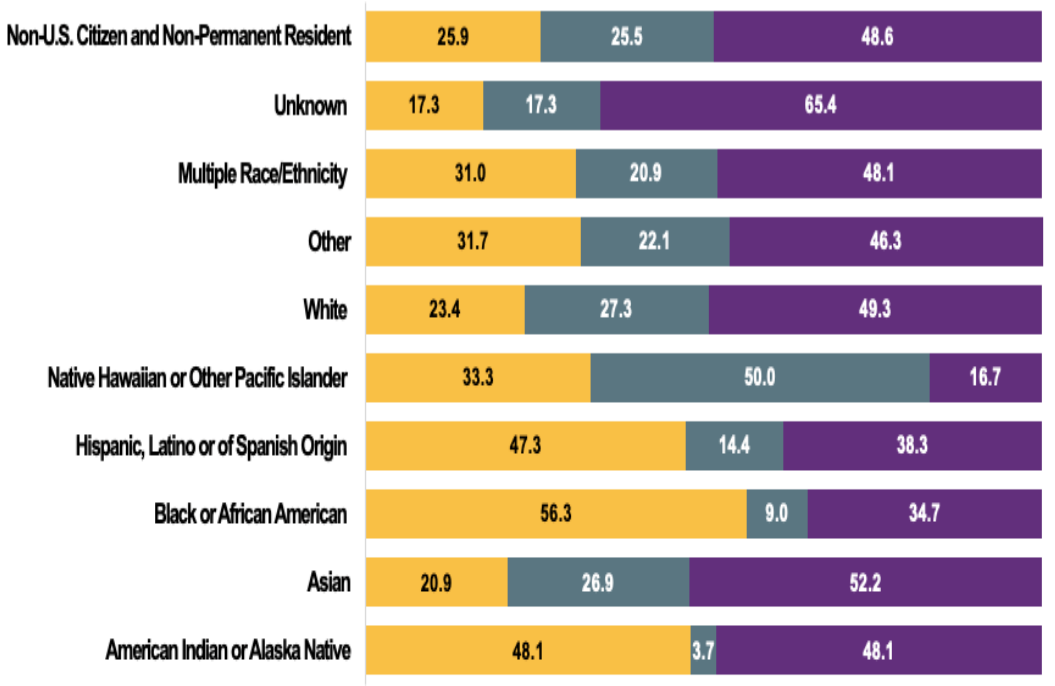
- We live in racially segregated communities
- Disease burden and health and healthcare inequities are strongly concentrated in residential areas of historically marginalized individuals
- People tend to seek medical care within their community
- Historically marginalized practitioners tend to practice in underserved communities and serve their historically marginalized residents
- There are high odds that a Black, Latinx or Asian physician will disproportionately see a patient of their same race or ethnicity
- The percentage of historically marginalized physicians trained in the US has not changed in 15 years

Can you predict who is more likely to serve underserved and marginalized communities?

AAMC Matriculating Student Questionnaire



AAMC Graduating Student Questionnaire



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.

Impact of racial concordance is greater in primary care

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.

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

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.

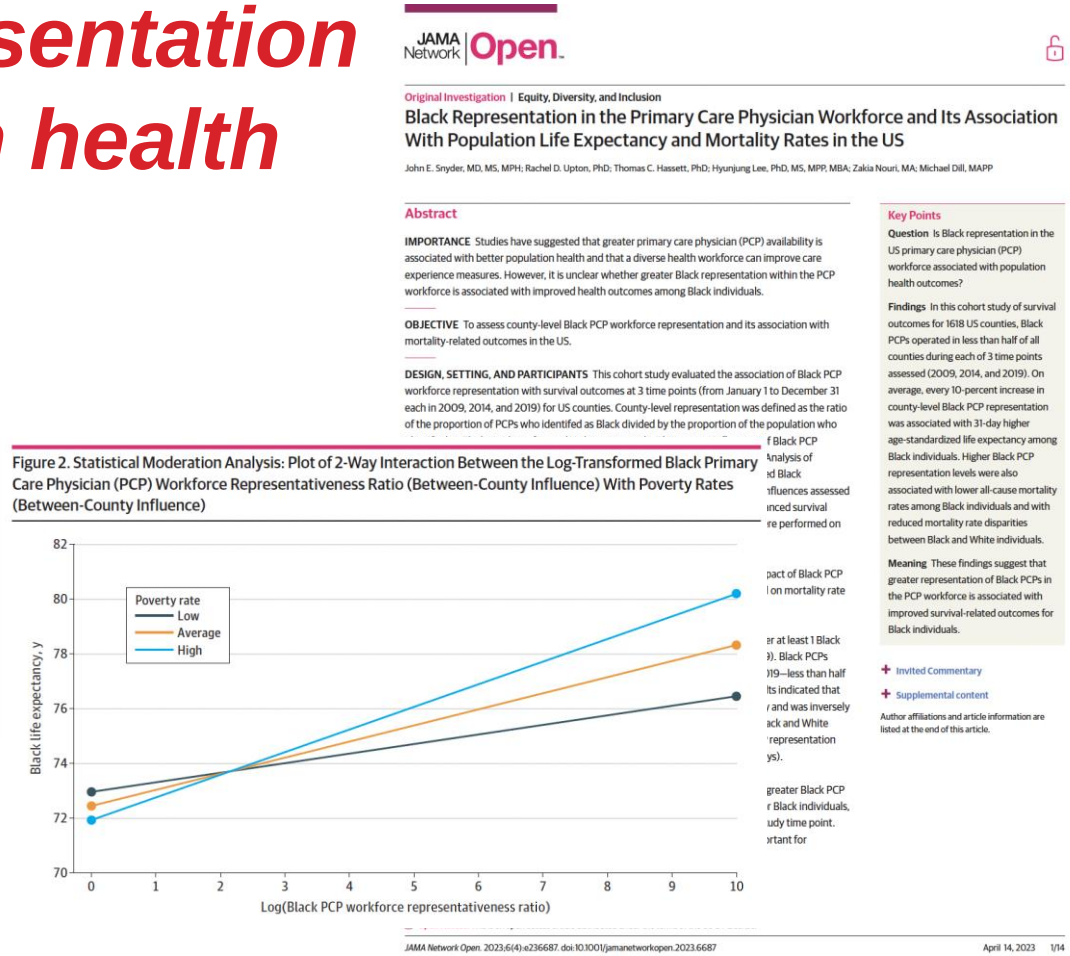
Greater Black PCP workforce representation is associated with better population health measures for Black individuals

Cohort study evaluated the association of Black PCP workforce representation with survival outcomes at 3 time points (2009, 2014, and 2019) for US counties.

Moderate workforce diversity gains occurred in the 10-year period from 2009 to2019, with a 9.8% increase in the number of US counties with 1 or more Black PCPs, still over half of all US counties had no Black PCPs

Greater Black PCP representation levels were associated with longer life expectancy and were inversely associated with all-cause mortality rates for Black individuals

Greater representation also was associated with a smaller difference in all-cause mortality rates between Black and White individuals



JAMA Network Open

Original Investigation | Equity, Diversity, and Inclusion

Black Representation in the Primary Care Physician Workforce and Its Association With Population Life Expectancy and Mortality Rates in the US

John E. Snyder, MD, MS, MPH; Rachel D. Upton, PhD; Thomas C. Hassett, PhD; Hyunjung Lee, PhD, MS, MPP, MBA; Zakia Nouri, MA; Michael Dill, MAPP

Abstract

IMPORTANCE Studies have suggested that greater primary care physician (PCP) availability is associated with better population health and that a diverse health workforce can improve care experience measures. However, it is unclear whether greater Black representation within the PCP workforce is associated with improved health outcomes among Black individuals.

OBJECTIVE To assess county-level Black PCP workforce representation and its association with mortality-related outcomes in the US.

DESIGN, SETTING, AND PARTICIPANTS This cohort study evaluated the association of Black PCP workforce representation with survival outcomes at 3 time points (from January 1 to December 31 each in 2009, 2014, and 2019) for US counties. County-level representation was defined as the ratio of the proportion of PCPs who identifed as Black divided by the proportion of the population who

Key Points

Question Is Black representation in the US primary care physician (PCP) workforce associated with population health outcomes?

Findings In this cohort study of survival outcomes for 1618 US counties, Black PCPs operated in less than half of all counties during each of 3 time points assessed (2009, 2014, and 2019). On average, every 10-percent increase in county-level Black PCP representation was associated with 31-day higher age-standardized life expectancy among Black individuals. Higher Black PCP representation levels were also associated with lower all-cause mortality rates among Black individuals and with reduced mortality rate disparities between Black and White individuals.

Meaning These findings suggest that greater representation of Black PCPs in the PCP workforce is associated with improved survival-related outcomes for Black individuals.

+ Invited Commentary
+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Figure 2. Statistical Moderation Analysis: Plot of 2-Way Interaction Between the Log-Transformed Black Primary Care Physician (PCP) Workforce Representativeness Ratio (Between-County Influence) With Poverty Rates (Between-County Influence)

JAMA Network Open. 2023;6(4):e236687. doi:10.1001/jamanetworkopen.2023.6687 April 14, 2023 1/14

$$\text{Community representativeness ratio} = \frac{\left(\frac{\text{No. of Black PCPs in a county}}{\text{All PCPs in a county}}\right)}{\left(\frac{\text{No. of Black individuals in a county}}{\text{All individuals in a county}}\right)}$$

Snyder, J.E., Upton, R.D., Hassett, T.C., Lee, H., Nouri, Z. and Dill, M., 2023. Black representation in the primary care physician workforce and its association with population life expectancy and mortality rates in the US. *JAMA Network Open*, *6*(4), pp.e236687-e236687.

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

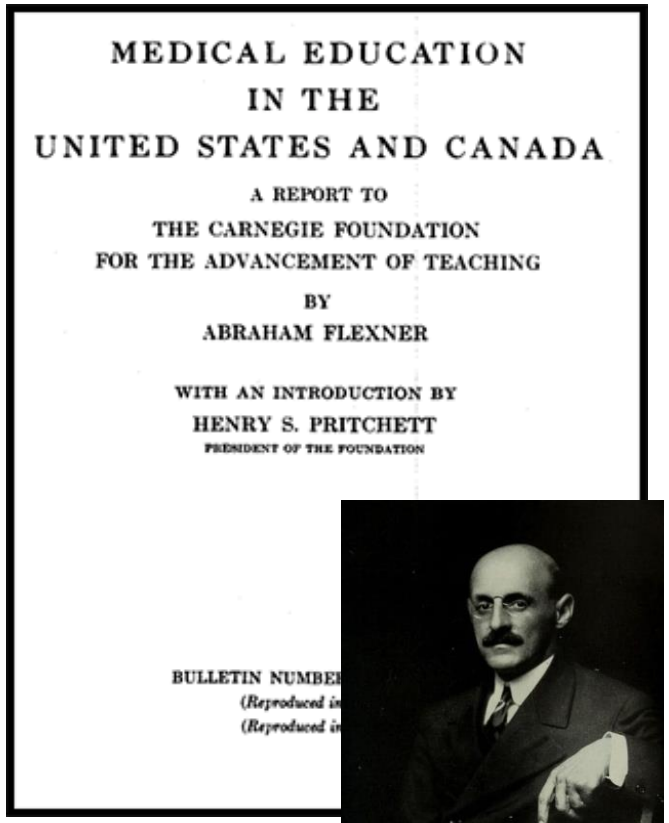
Increasing racial/ethnic diversity in the physician workforce supports concordance

- Isn’t forcing people to work where they don’t want to work
- Isn’t limiting patient access to only racially concordant physicians
- Isn’t stopping patients from seeing the most appropriate physician

- 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

Concordant care has been the foundation of a century of American medical education

Stems from the Flexner report in 1910 that stated the reason to leave the two Black medical schools in place, after recommending closure of the other five at the time, was to ensure a supply of negro physicians to serve the black population to prevent spread of disease to the overall population.



MEDICAL EDUCATION
IN THE
UNITED STATES AND CANADA

A REPORT TO
THE CARNEGIE FOUNDATION
FOR THE ADVANCEMENT OF TEACHING

BY
ABRAHAM FLEXNER

WITH AN INTRODUCTION BY
HENRY S. PRITCHETT
PRESIDENT OF THE FOUNDATION

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CHAPTER XIV

THE MEDICAL EDUCATION OF THE NEGRO

THE medical care of the negro race will never be wholly left to negro physicians. Nevertheless, if the negro can be brought to feel a sharp responsibility for the physical integrity of his people, the outlook for their mental and moral improvement will be distinctly brightened. The practice of the negro doctor will be limited to his own race, which in its turn will be cared for better by good negro physicians than by poor white ones. But the physical well-being of the negro is not only of moment to the negro himself. Ten million of them live in close contact with sixty million whites. Not only does the negro himself suffer from hookworm and tuberculosis; he communicates them to his white neighbors, precisely as the ignorant and unfortunate white contaminates him. Self-protection not less than humanity offers weighty counsel in this matter; self-interest seconds philanthropy. The negro must be educated not only for his sake, but for ours. He is, as far as human eye can see, a permanent factor in the nation. He has his rights and due and value as an individual; but he has, besides, the tremendous importance that belongs to a potential source of infection and contagion.

The pioneer work in educating the race to know and to practise fundamental hygienic principles must be done largely by the negro doctor and the negro nurse. It is important that they both be sensibly and effectively trained at the level at which their services are now important. The negro is perhaps more easily "taken in" than the white; and as his means of extricating himself from a blunder are limited, it is all the more cruel to abuse his ignorance through any sort of pretense. A well-taught negro sanitarian will be immensely useful; an essentially untrained negro wearing an M.D. degree is dangerous.

Make-believe in the matter of negro medical schools is therefore intolerable. Even good intention helps but little to change their aspect. The negro needs good schools rather than many schools,— schools to which the more promising of the race can be sent to receive a substantial education in which hygiene rather than surgery, for example, is strongly accentuated. If at the same time these men can be imbued with the missionary spirit so that they will look upon the diploma as a commission to serve their people humbly and devotedly, they may play an important part in the sanitation and civilization of the whole nation. Their duty calls them away from large cities to the village and the plantation, upon which light has hardly as yet begun to break.

Projected estimates of Black physicians

Flint Medical College of New Orleans University, Knoxville Medical College, Leonard Medical School of Shaw University, Louisville National Medical College, and the University of West Tennessee College of Medicine and Surgery–Memphis were recommended for closure

If the 5 closed historically Black medical schools had remained open, steady expansion and rapid expansion models indicated in this paper suggest that these schools might have collectively provided training to an additional 27 773 graduates and 35 315 graduates, respectively

By extrapolation, the number of graduating Black physicians might have increased by 355 individuals (29%) in 2019 alone

JAMA Network Open

Original Investigation | Medical Education

Projected Estimates of African American Medical Graduates of Closed Historically Black Medical Schools

Kendall M. Campbell, MD; Irma Corral, PhD, MPH; Jhojana L. Infante Linares, MS; Dmitry Tumin, PhD

Abstract

IMPORTANCE There continue to be low numbers of underrepresented minorities, including African Americans, in academic medicine. Historically Black medical colleges and universities are major sources of training for medical school graduates who are African American or who belong to other underrepresented minority groups. Several historically Black medical schools were closed during the period surrounding the 1910 Flexner report. The implications of these school closures with regard to the number of African American medical school graduates have not been fully examined.

OBJECTIVE To examine the consequences associated with the closure of historically Black medical schools for the number of African American medical school graduates.

DESIGN, SETTING, AND PARTICIPANTS This observational economic evaluation used steady expansion and rapid expansion models to estimate the consequences associated with the closure of historically Black medical schools for the number of African American medical school graduates. The numbers of graduates from 13 historically Black medical schools that are now closed were obtained through historical records. Data on historically Black medical schools that are currently open were obtained from school-specific reports and reports published by the Association of American Medical Colleges. The study focused on projected estimates of outcomes from the hypothetical continued operation and expansion of 5 closed historically Black medical schools that were included in the Flexner report: Flint Medical College of New Orleans University, Knoxville Medical College, Leonard Medical School of Shaw University, Louisville National Medical College, and the University of West Tennessee College of Medicine and Surgery–Memphis.

MAIN OUTCOMES AND MEASURES The main outcome was the estimate of the number of African American students who would have graduated from historically Black medical schools that were closed during the period surrounding the 1910 Flexner report.

RESULTS Among the 5 historically Black medical schools that were closed, the estimated mean number of graduates per year was 5.27 students at Flint Medical College, 2.60 students at Knoxville Medical College, 11.06 students at Leonard Medical School, 4.17 students at Louisville National Medical College, and 6.74 students at the University of West Tennessee. If the 5 closed historically Black medical schools had remained open, the steady expansion and rapid expansion models indicated that these schools might have collectively provided training to an additional 27 773 graduates and 35 315 graduates, respectively, between their year of closure and 2019. In the analysis of Leonard Medical School and the University of West Tennessee only, the steady expansion and rapid expansion models indicated that these 2 schools would have provided training to an additional 10 587 graduates and 13 403 graduates, respectively, between their year of closure and 2019. An extrapolation based on the racial and ethnic self-identification of current graduates of historically Black medical schools indicated that if these closed schools had remained open, the number of

Key Points

Question What are the projected estimates of the number of African American students who would have graduated from historically Black medical schools that were closed during the period surrounding the publication of the 1910 Flexner report?

Findings In this economic evaluation of 13 historically Black medical schools that were closed and 4 historically Black medical schools that remained open after the 1910 Flexner report, an extrapolation based on data from the medical schools that remained open indicated that 5 of the closed medical schools might have collectively provided training to an additional 35 315 graduates by 2019. If these 5 closed schools had remained open, they could have produced a 29% increase in the number of graduating African American physicians in 2019 alone.

Meaning The study's findings suggest that consideration should be given to the creation of medical education programs at historically Black colleges and universities in an effort to increase the number of African American graduates from medical schools and the number of African American physicians in the workforce.

+ Editorial and Invited Commentary

Author affiliations and article information are listed at the end of this article.

Campbell, K.M., Corral, I., Linares, J.L.I. and Tumin, D., 2020. Projected estimates of African American medical graduates of closed historically Black medical schools. *JAMA network open*, *3*(8), pp.e2015220-e2015220.

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/improved communication

Psychological and physical safety

Trust, respect

Perceived shared worldview

Proximal location

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

Race-conscious professionalism[1]

- 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

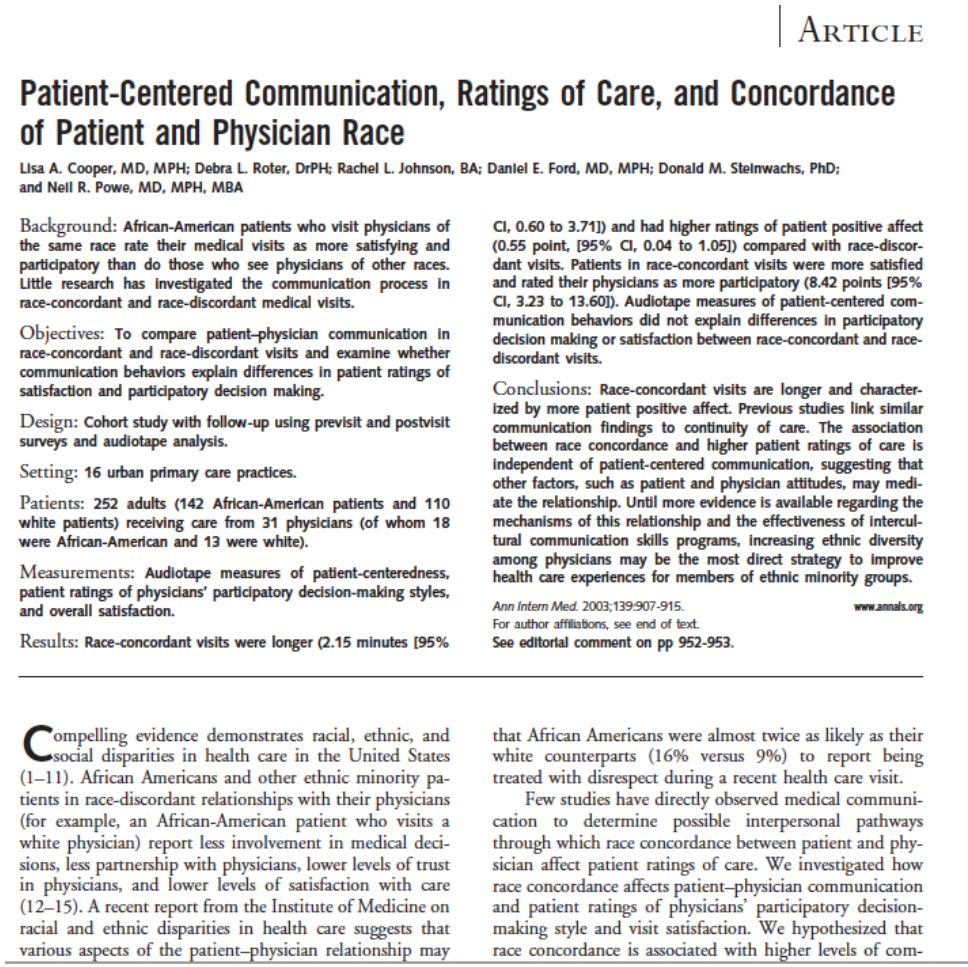
[1]Powers, BW et al. Academic Medicine 2016. 91(7):913-5

Patient-centered communication does not fully explain heightened satisfaction in concordance

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

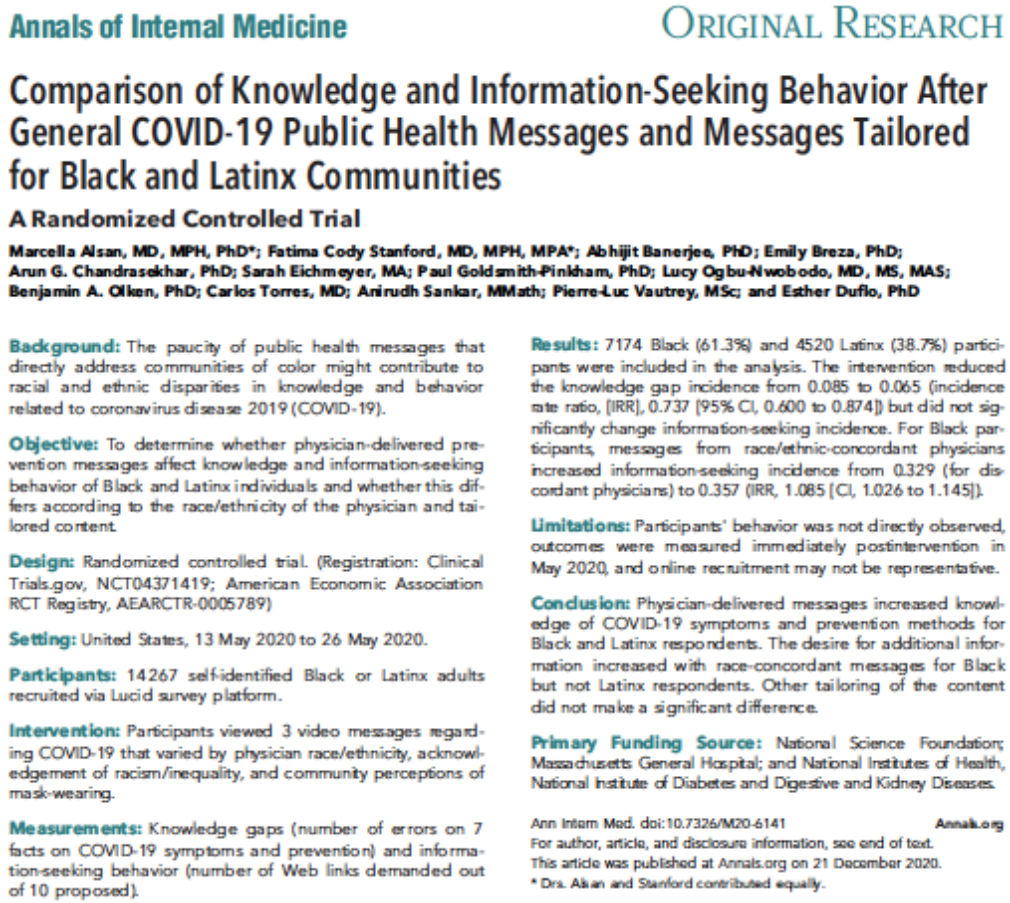
Concordance and communication

[1]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.

[2]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.

Ann Intern Med. doi:10.7326/M20-6141 Annals.org
For author, article, and disclosure information, see end of text.
This article was published at Annals.org on 21 December 2020.
* Drs. Alsan and Stanford contributed equally.

[1]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).

[2]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).

Race-conscious professionalism

Describes the process black professionals confront when attempting to navigate the competing demands of professionalism, racial obligations, and personal integrity

Hispanic and black physicians tend to not leave minority communities once they settle in such areas, and when they move, they tend to move to areas similar to those that they are from.

Wilkins D. Identities and roles: Race, recognition, and professional responsibility. MD Law Rev. 1998. 57:1502–1595.

Brown T et al. Does the under- or overrepresentation of minority physicians across geographical areas affect the location decisions of minority physicians? Health Serv Res 2009 44(4):1290-308

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

Brian W. Powers, Nancy E. Oriol, Sachin H. Jain Journal of Health Care for the Poor and Underserved, Volume 26, Number 1, February 2015, pp. 73-81

Burden of expectation

Privilege for some and obligation for others

Assumptions associated with typical gender norms; ethnicity biases; medical students' socialization and professional development (most notably with regard to career expectations)

Explicit, implicit, and even hidden institutional-level barriers and hurdles for URM students

Central character in this case-study attended medical school "thanks to an institutional scholarship and federal financial aid, and societal expectations that can be associated with this kind of support for students, specifically those who are members of underrepresented in medicine groups.

AMA Journal of Ethics®
March 2017, Volume 19, Number 3: 238-244

ETHICS CASE

Why It's Unjust to Expect Location-Specific, Language-Specific, or Population-Specific Service from Students with Underrepresented Minority or Low-Income Backgrounds

Commentary by Barret Michalec, PhD, Maria Athina (Tina) Martimianakis, PhD, Jon C. Tilburt, MD, MPH, and Frederic W. Hafferty, PhD

Abstract

In this case we meet Amanda, a medical student of Native and Latin American ethnicity who receives financial aid. Her friends are surprised by her interest in an elite residency program. They suggest, rather, that with her language skills, ethnic background, and interest in social justice, she has a responsibility to work with underserved patient populations. In our commentary, we consider issues raised by the case and explore Amanda's friends' underlying expectations and assumptions that perpetuate the very inequities that the resolution of the case purports to address. We also identify the role of privilege and address the "burden of expectation" that appears to be associated with underrepresented minority (URM) medical students and normative assumptions about their career paths.

Case

Amanda is a second-year medical student at a private Midwestern medical school, which she is able to attend thanks to an institutional scholarship and federal financial aid. She has been seriously engaged with campaigns on campus for health equity and social justice in the community and in the country at large. Amanda grew up in a family with mixed Native American and Latin American roots and was a first-generation college graduate in her family; thus, issues of access to education and health care are very important to her.

Amanda grew up speaking Spanish fluently and studied medical Chinese in her first year of medical school. She has used her language skills in a medical student-run clinic that provides free basic clinical services to those with limited English proficiency (LEP), which includes Spanish and Chinese speakers. As a second-year medical student, she has begun thinking about clinical years and plans for a successful residency match. During her recent visit with her family over Christmas, her parents and maternal grandmother

Michalec, Barret, et al. "Why It's Unjust to Expect Location-Specific, Language-Specific, or Population-Specific Service from Students with Underrepresented Minority or Low-Income Backgrounds." *AMA journal of ethics* 19.3 (2017): 238-244.

Privilege

Shroud of privilege—social advantages (often race or ethnicity and gender-based) that protect certain people and provide a more clearly paved path to upward social mobility in comparison to others who encounter explicit and implicit hurdles and pitfalls (e.g., institutionalized sexism and racism).

Privilege is reflected in their apparent assumption that they do not have responsibility to work with underserved patient populations and that they somehow see themselves as more free than Amanda to explore their own professional interests

Michalec, Barret, et al. "Why It's Unjust to Expect Location-Specific, Language-Specific, or Population-Specific Service from Students with Underrepresented Minority or Low-Income Backgrounds." *AMA journal of ethics* 19.3 (2017): 238-244.

What responsibility do we all have to serve the underserved?

Medicine, foundationally, is a service profession and that all medical professionals have a fiduciary responsibility to serve diverse patient populations. In contrast to her classmates, the central character is attributed a burden of service because of her ethnic identity, language skills, and having previously worked to alleviate health inequities.

Skills stemming in part from her ethnicity make her more naturally suited for work in URM communities and chain her to an expectation of altruistic medical “servitude”

The text does not say that they expect Amanda to join them in service to minority, immigrant, and LEP patients rather they are protected from this mantle of responsibility because of their privilege.

Michalec, Barret, et al. "Why It’s Unjust to Expect Location-Specific, Language-Specific, or Population-Specific Service from Students with Underrepresented Minority or Low-Income Backgrounds." *AMA journal of ethics* 19.3 (2017): 238-244.

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 CV mortality

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

Flu shots were significantly more likely in concordant pairings

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

M Alsan, O Garrick, and GC Graziani, NBER Working Paper No. 24787, June 2018, Revised September 2018

Patient-physician race/ethnicity concordance improves adherence to cardiovascular disease guidelines

Patient-physician race/ethnicity concordance was associated with adherence to four of our six outcome measures: **A**spirin (IRR = 1.08, 95% CI: 1.03-1.14, P < .001); **B**lood pressure control (IRR = 1.09, 95% CI: 1.07-1.12, P < .001); smoking screening and cessation (IRR = 1.06, 95% CI: 1.04-1.08, P < .001); and **ABC** composite (IRR = 1.42, 95% CI: 1.33-1.52, P < 0.001). They did not find an association for race/ethnicity concordance with **C**holesterol and smokers counseled

recommended VAD over transplant for all racial/sex groups. Surveys demonstrated similar final recommendations.

Conclusions: Despite identical clinical vignettes, the decision making process varied by patient sex and race. Women patients were judged more harshly by their appearance and adequacy of social support, particularly the African American woman.

Implications for Policy or Practice: Future research should investigate whether objective assessments of social support lead to equity in advanced therapy allocation.

Primary Funding Source: National Institutes of Health.

Patient-Physician Race/Ethnicity Concordance Improves Adherence to Cardiovascular Disease Guidelines

A.M. Nguyen[1]; N. Siman[1]; M. Barry[1]; C.M. Cleland[2]; H. Pham-Singer[3]; O. Ogedegbe[2]; C. Berry[4]; D. Shelley[5]

[1]NYU Langone Health, New York, NY, United States; [2]New York University School of Medicine, New York, NY, United States; [3]New York City Department of Health and Mental Hygiene, Long Island City, NY, United States; [4]Department of Population Health, NYU Langone Health, New York, NY, United States; [5]NYU College of Global Public Health, New York, NY, United States

Research Objective: Studies have found that race/ethnicity concordance between patients and providers improves medication adherence among patients with hypertension and single CVD outcomes (eg, blood pressure control). Our objective was to examine the association of patient-physician race/ethnicity concordance on adherence to the Million Hearts "ABCS" CVD guidelines: (A) aspirin when indicated, (B) blood pressure control, (C) cholesterol management, and (S) smoking screening and cessation. To the best of our knowledge, this is the first study to examine the impact of race/ethnicity concordance on guideline adherence to multiple CVD outcome measures.

Study Design: This study was part of HealthyHearts NYC, a stepped-wedge cluster randomized controlled trial funded through AHRQ's EvidenceNOW initiative to test the effectiveness of practice facilitation on helping primary care practices adhere to CVD guidelines. The main outcomes were the Million Hearts' ABCS measures. Two additional measures were created: (a) proportion of patients who use tobacco who received a cessation intervention (smokers counseled) and (b) a composite measure that assessed the proportion of patients meeting treatment targets for A, B, and C (ABC composite). Practice-level outcome data were extracted for thirteen quarters from practices' electronic health record (EHR) systems, encompassing the control, intervention, and follow-up periods of the intervention. Patient-physician race/ethnicity concordance was calculated using patient race/ethnicity data extracted from the practices' EHR and physician race/ethnicity data collected via a Provider Survey. The concordance measure was calculated as the proportion of patients with the same race/ethnicity as the physician, for example, if practice is led by an Asian physician, and patients are 33% non-Hispanic white, 5% non-Hispanic black, 5% Hispanic, and 57% Asian, the concordance is 0.57.

Population Studied: 211 small primary care practices in NYC.

Principal Findings: 57.7% of Hispanic, 53.6% of black, 73.6% of Asian, 74.2% of non-Hispanic white, and 24.1% of Hawaiian/Pacific Islander patients had the same race/ethnicity as their physicians. 44.7% of physicians had the same race/ethnicity as at least 70% of their patients. Patient-physician race/ethnicity concordance was associated with adherence to four of our six outcome measures: aspirin (IRR = 1.08, 95% CI: 1.03-1.14, $P < .001$); blood pressure (IRR = 1.09, 95% CI: 1.07-1.12, $P < .001$); smoking screening and cessation (IRR = 1.06, 95% CI: 1.04-1.08, $P < .001$); and ABC composite (IRR = 1.42, 95% CI: 1.33-1.52, $P < 0.001$). We did not find an association for race/ethnicity concordance with Cholesterol and Smokers Counseled.

Conclusions: Increasing opportunities for patient-physician race/ethnicity concordance may improve adherence to CVD guidelines. The largest improvement was observed in the ABC Composite measure, suggesting that patient-physician race/ethnicity concordance is particularly important for managing medically complex patients who have multiple chronic diseases.

Implications for Policy or Practice: Health policy should fund programs that support the recruitment and retention of a wide diversity of students and faculty to increase the level of concordance in patient-clinician encounters. Policy makers may also want to consider legislation to help support or protect small practices that predominantly serve communities of color, where a large proportion of the physicians may be racially/ethnically concordant with the patient population. Medical education programs should incorporate patient-physician communication training to minimize gaps potentially created by race/ethnicity discordance.

Primary Funding Source: Agency for Healthcare Research and Quality.

Minimizing Defensiveness in Clinician Education about Implicit Bias: Lessons Learned from a Community-Engaged Randomized Clinical Trial

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Research Objective: Clinicians' implicit bias can affect quality of healthcare delivery and contribute to healthcare disparities. How

Nguyen, A.M., Siman, N., Barry, M., Cleland, C.M., Pham-Singer, H., Ogedegbe, O., Berry, C. and Shelley, D., 2020. Patient-Physician Race/Ethnicity Concordance Improves Adherence to Cardiovascular Disease Guidelines. *Health Services Research*, *55*, pp.51-51.

Physician 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

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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.

Greenwood, B.N., Hardeman, R.R., Huang, L. and Sojourner, A., 2020. Physician–patient racial concordance and disparities in birthing mortality for newborns. *Proceedings of the National Academy of Sciences*, *117*(35), pp.21194-21200.

Utilization is improved and expenditures decreased with concordant care

Analyzed 50,626 patients in the Medical Expenditure Panel Survey 2010-16

ED usage was less for Whites and Hispanics with concordant physicians

NHW who were publicly insured or with poor health status were more likely to have a discordant physician

Hispanic and Asian patients who were not proficient in English were more likely to have a concordant physician

Asian patients who had a concordant physician were 30% less likely to have an ED visit and 25% less likely for Hispanic patients. Hispanics also had lower hospitalizations

Screening tests for breast cancer were increased in concordant relationships

Total healthcare expenditures were less for Black, Asian and Hispanic patients in concordant relationships (14%, 34%, 20%). Also true for Asian, and Hispanic patients in concordant relationships for outpatient care. Inpatient care and prescriptions were less for Black patients in concordant care.

Jetty, A., Jabbarpour, Y., Pollack, J., Huerto, R., Woo, S. and Petterson, S., 2022. Patient-physician racial concordance associated with improved healthcare use and lower healthcare expenditures in minority populations. *Journal of racial and ethnic health disparities*, *9*(1), pp.68-81

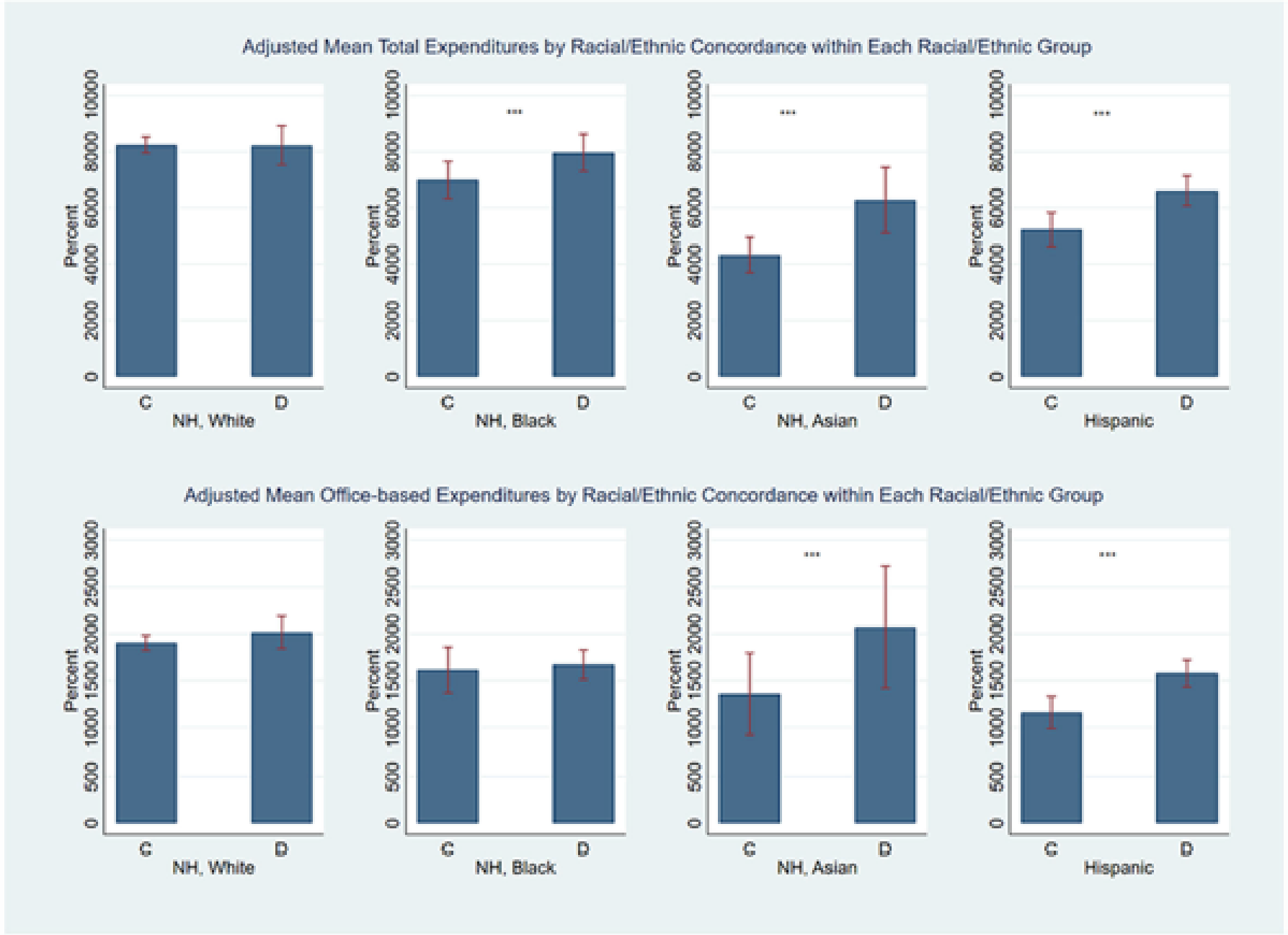


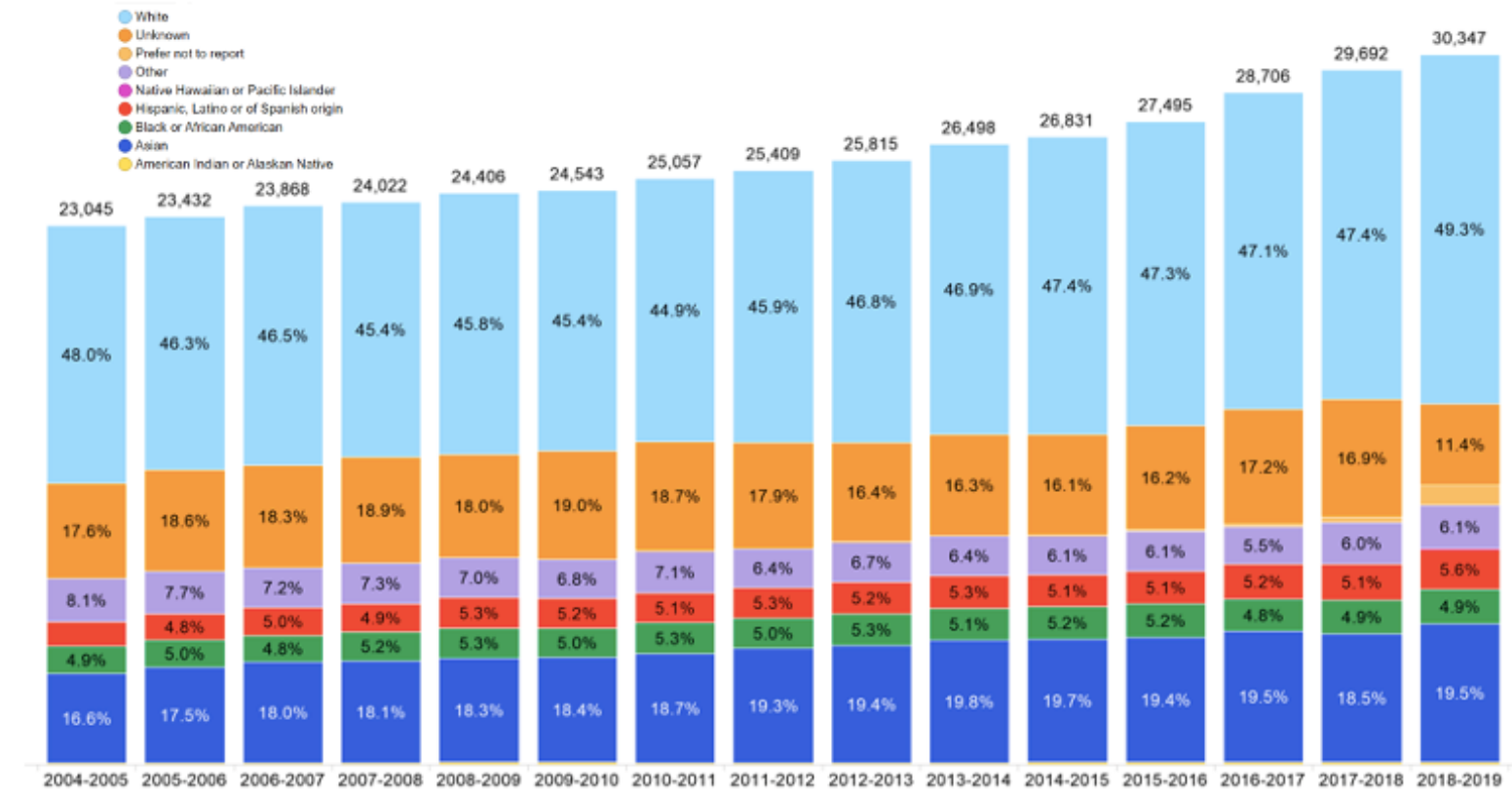
Fig. 2 Adjusted mean total and office-based expenditures by race concordance within each racial/ethnic group, pooled MEPS (2010–2016).[a] Notes: NH, non-Hispanic; C, concordant; D, discordant. [a]Adjusted for gender, age, region, education, poverty, insurance coverage, poor health status, marital status, number of chronic conditions, nativity status, duration of stay in the USA, and survey year. ***$p < 0.01$, **$p < 0.05$

Jetty, A., Jabbarpour, Y., Pollack, J., Huerto, R., Woo, S. and Petterson, S., 2022. Patient-physician racial concordance associated with improved healthcare use and lower healthcare expenditures in minority populations. *Journal of racial and ethnic health disparities*, *9*(1), pp.68-81

Hazard of depending on racially concordant care to eliminate health disparities

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[1] to improve the care they give to patients from historically marginalized groups



ACGME Data Resource Book Academic Years 2004-2019

[1]Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Care Poor Underserved. 1998;9:117–25.

ACGME follow up of the SCOTUS decision

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Follow-Up to Dr. Nasca's June 13 Letter to the Community after Supreme Court Decision Regarding College Admissions and Race

News | *12 July 2023*

Share This

This is a follow-up to the June 13 Letter to the Community addressing the accreditation implications of the Students for Fair Admissions, Inc v. President and Fellows of Harvard College Supreme Court case.

Dear Members of the Graduate Medical Education Community,

On June 29, 2023, the United States Supreme Court issued its decisions in *Students for Fair Admissions, Inc. v. President and Fellows of Harvard College*, addressing the consideration of race-based affirmative action in university admissions. Since that decision and the passage of certain state laws that limit diversity, equity, and inclusion activities, the ACGME has received inquiries relating to the accreditation standards that require engaging "in practices that focus on mission-driven,

KEY TOPICS

- Annual Educational Conference
- COVID-19
- Diversity, Equity, and Inclusion
- Residents and Fellows
- Well-Being

View All Topics

CONTACT

Susan Holub

Follow-up

- ACGME reaffirms it commitment to its requirements to focus on diversity through a mission-driven, ongoing, systematic effort of recruitment and retention of a diverse and inclusive workforce of residents, fellows, faculty members, senior administrative GME staff members and other relevant members of its academic community

- The rationale for this is to hold true to ACGME's mission to improve health and population health. Elimination of racial and ethnic health disparities is central to improving health of society

- ACGME requirements do not require race-based affirmative action to achieve diversity and the decision does not require programs to change their current selection practices.

Common Program Requirement I.C.

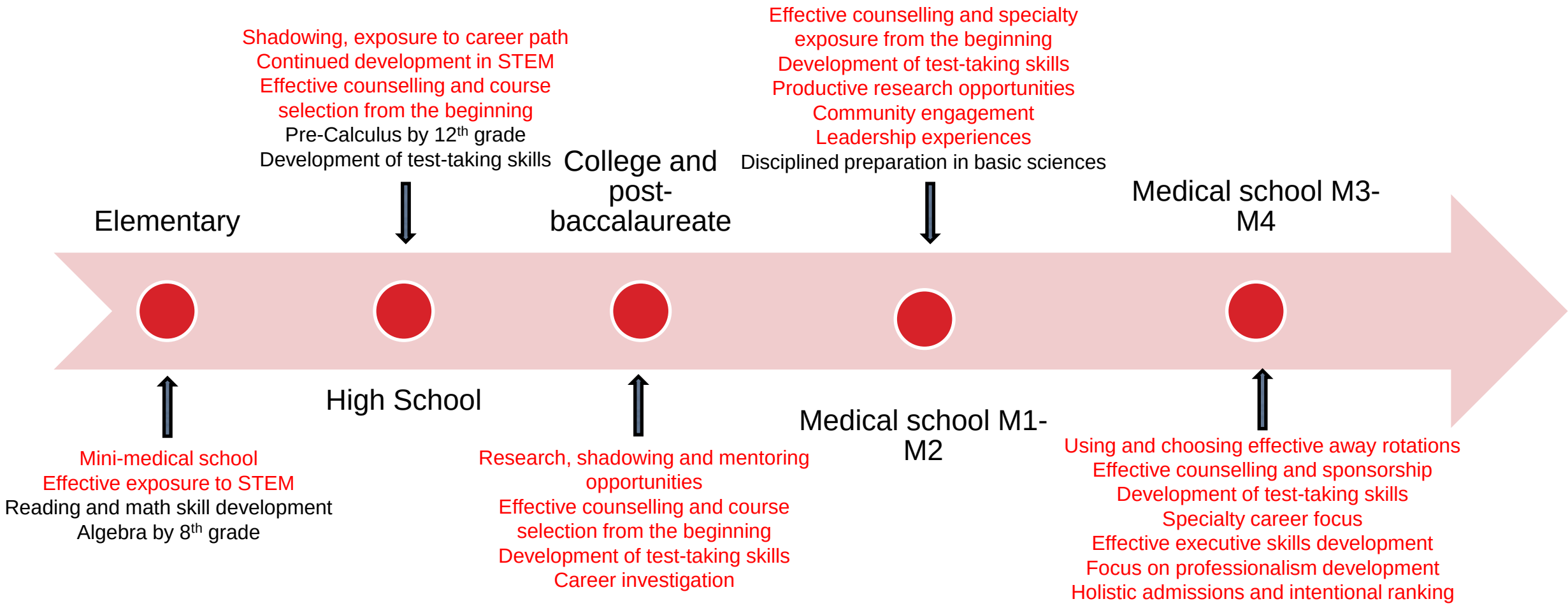
I.C. The Program, in partnership with its Sponsoring Institution, **must** engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)

Adopted by ACGME Board of Directors June 2018

Changes went into effect 1 July 2019

https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2023.pdf

Production of clinicians is a long-term process with multiple points of intervention



“We don’t control the entry of students into medicine, so there’s nothing we can do to advance diversity”

National Initiative IX

Addressing the Social and Moral Determinants of Health

NI IX Addressing the Social and Moral Determinants of Health will be an eighteen-month initiative that features monthly Zoom cohorts or webinars and four in-person meetings*. Monthly cohort groups will be structured by themes based on focus areas identified in the applications, with best practices from all cohort groups shared at the meetings. Learning session topics will include discussions on the social and moral determinants of health; strategies to counteract these determinants; and the importance of creating and fostering environments that serve all our patients regardless of their circumstances. (*Please note that Meeting Three will be virtual.)

The AIAMC's sixteen years of experience with eight successful National Initiatives provide a rich and unique resource to the CLE community. We have engaged numerous key leaders, including the Accreditation Council for Graduate Medical Education (ACGME), American Hospital Association (AHA), American Medical Association (AMA) and the American Association of Colleges of Osteopathic Medicine (AACOM) and look forward to their continued input and support. The AIAMC is also an inaugural member of the National Collaborative for Improving the Clinical Learning Environment (NCICLE), facilitated by the ACGME and represented by more than 40 major health care organizations working to improve the educational experience and patient care outcomes within clinical learning environments.

WHY Social and Moral Determinants of Health?

Social Determinants of Health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. They are well documented, yet too often ignored by those providing care3. The Accreditation Council for Graduate Medical Education (ACGME) updated the Common Program Requirements effective July 1, 2023 to reflect the urgency for a systematic recruitment and retention of a diverse workforce of trainees, faculty, and education/academic staff, that professionalism requires residents to demonstrate competence in respect and responding to diverse patient populations, and that residents must demonstrate an awareness of a responsiveness to the larger context and system of health care including structural and social determinants of health and equity (systems-based practice).

OBJECTIVES AND OUTCOMES OF NATIONAL INITIATIVE IX

At the end of NI IX, each participant will have engaged their clinical learning environment in addressing social and moral determinants of health. Specific goals and outcomes for NI IX include:

Addressing the Social and Moral Determinants of Health

- Read and be able to articulate local Community Health Needs Assessment (CHNA)
- Assess social and moral determinants of health (SMDH)
- Establish and measure programs for learners and others related to SMDH
- Engage the C-Suite in a review of Medicare requirements and how SMDH affect the clinical learning environment
- Significantly and measurably advance the clinical learning environment's efforts in SMDH, disseminating results within your organization's Micro, Meso, and Macro environments

ACGME Office of Diversity, Equity, and Inclusion

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Thank you