Racial Concordance, Rather Than Cultural Competency Training, Can Change Outcomes

TO THE EDITOR:

In their article, "Physician Cultural Competency Training and Impact on Behavior: Evidence From the 2016 National Ambulatory Medical Care Survey," the authors conclude that cultural competency training has likely been integrated into medical education and that there was no difference in behavior toward patients between those who received cultural competency training and those who did not.[1] We applaud the authors for taking this deep dive into the impact of cultural competency training, and we recognize that there continues to be an effort to improve the care of our patients. Cultural competency training has been shown to increase provider knowledge and confidence with caring for multicultural patients, yet there is little evidence that broader goals of improved patient outcomes are achieved.[2] Racial concordance, however, has been shown to improve patient outcomes and should be the new focus of all institutions seeking to reduce health inequities.[3]

Provider-patient race concordance can achieve broader, systemic goals of improving cross-cultural care delivery and improved patient outcomes.[4] For instance, racial concordance is more clearly associated with better communication between patients and providers in one systematic review that involved Black patients.[3] Another health system showed higher Press Ganey patient satisfaction scores between racially/ethnically concordant patients and their physicians.[4] Other studies showed a greater patient acceptance of invasive procedures during preventative visits (eg, blood draws and injections) and improved show rates for longitudinal care visits between race-concordant patients and physicians.[5,6] In view of this, cultural competency efforts and resources can be shifted toward recruiting, training, and integrating more racially concordant providers to reduce health inequities.

We call upon academic institutions and our health care system at large to invest in programs and initiatives that aim to recruit, retain, and advance underrepresented in medicine (URIM) students and disadvantaged people of color into the field of medicine. This can include creating effective prehealth pathway programs in low-income communities[7] as well as partnering with the Student National Medical Association to help with the recruitment of URIM students into medical school.[8] For residency recruitment, it includes reducing sources of unintended bias and increasing value placed on journey travelled, both of which have been associated with improved matching rates of underrepresented minorities in family medicine.[9,10] While cultural competence training is likely ubiquitous, increasing racial concordance of the health care workforce and patients can reduce health inequities. The sooner we shift, the quicker we can see results.

doi: 10.22454/FamMed.2022.633693

Gina Guillaume, MD
North by Northeast Community Health Center
Portland, OR

Juan C. Robles, MD
Albert Einstein College of Medicine
Bronx, NY

José E. Rodríguez, MD
University of Utah Health
Salt Lake City, UT

References

1. Mainous AG, Xie Z, Yadav S, Williams M, Blue AV, Hong YR. Physician cultural competency training and impact on behavior: evidence from the 2016 national ambulatory medical care survey. Fam Med. 2020;52(8):562-569. doi:10.22454/FamMed.2020.163135
2. Shepherd SM. Cultural awareness workshops: limitations and practical consequences. BMC Med Educ. 2019;19(1):14. doi:10.1186/s12909-018-1450-5
3. Shen MJ, Peterson EB, Costas-Muñiz R, et al. The effects of race and racial concordance on patient-physician communication: a systematic review of the literature. J Racial Ethn Health Disparities. 2018;5(1):117-140. doi:10.1007/s40615-017-0350-4
4. Takeshita J, Wang S, Loren AW, et al. Association of racial/ethnic and gender concordance between patients and physicians with patient experience ratings. JAMA Netw Open. 2020;3(11):e2024583. doi:10.1001/jamanetworkopen.2020.24583
5. Alsan M, Garrick O, Graziani G. Does diversity matter for health? experimental evidence from Oakland. American Economic Review. 2019;109(12):4071-4111. doi:10.1257/aer.20181446
6. Ma A, Sanchez A, Ma M. The impact of patient-provider race/ethnicity concordance on provider visits: updated evidence from the medical expenditure panel survey. J Racial Ethn Health Disparities. 2019;6(5):1011-1020. doi:10.1007/s40615-019-00602-y

7. Robles J, Qadeer R, Reyes Adames T, Naqvi Z. Impact of the Bronx community health leaders program for socioeconomically disadvantaged prehealth students. Health Equity. 2021;5(1):791-800. doi:10.1089/heq.2021.0065
8. Figueroa O. The significance of recruiting underrepresented minorities in medicine: an examination of the need for effective approaches used in admissions by higher education institutions. Med Educ Online. 2014;19:24891. doi:10.3402/meo.v19.24891
9. Stoesser K, Frame KA, Sanyer O, et al. Increasing URiM family medicine residents at University of Utah Health. PRiMER. 2021;5:42. doi:10.22454/PRiMER.2021.279738
10. Wusu MH, Tepperberg S, Weinberg JM, Saper RB. Matching our mission: a strategic plan to create a diverse family medicine residency. Fam Med. 2019;51(1):31-36. doi:10.22454/FamMed.2019.955445

Racial Bias in Test Performance: Primary Language and a More Holistic Knowledge Assessment

TO THE EDITOR:

We applaud the efforts of Wang et al to address systemic racism in their paper on racial differences in family medicine residency, in-training exam scores.[1] However, we were disappointed the researchers did not address the differences in exam performance of test takers using English as a second language (ESL). Primary language has long been shown to be an important factor when taking timed exams in English.[2] Test takers using ESL have been found to have particular difficulty with lengthy clinical vignettes.[3] International medical graduates made up over 30% of the sample and were found to have lower overall initial exam scores and more rapid improvement during residency. Even if the current data collection does not include primary language or ESL, the ABFM does collect data on respondents' use of languages other than English for care delivery.[4] This could be a valuable proxy measure for ESL and might help sort out the differential impact of language versus race/ethnicity on exam performance. Extending the time allowed for test completion has also been found to improve scores for those taking a knowledge test in a second language.[5] We caution the authors in anchoring on exam performance as the measure of resident knowledge acquisition without acknowledging the development of skills and other competencies that are less concretely assessed. Diversity has been shown to improve the quality of patient care.[6] STFM has set forth a strategic plan to increase diversity in family medicine educators and model "antiracism, health equity, and social justice themes in their materials" for learners and educators.[7] We recommend that STFM collaborates with the ABFM and other external organizations to also explore resident assessment using an equity lens. It is imperative that the ABFM determines a way to adequately assess the progression of medical knowledge of family medicine residents from diverse backgrounds. In the final paragraph, the authors equate exam performance with knowledge. We challenge this assumption and hope the ABFM will consider more holistic evaluation. The assessment of language and its impact on test performance would be an excellent first step.

doi: 10.22454/FamMed.2022.831717

John M. Westfall, MD, MPH
Robert Graham Center
Washington, DC

Erin C. Westfall, DO
Mayo Clinic Family Medicine Residency
Mankato, MN

References

1. Wang T, O'Neill TR, Eden AR, Taylor MK, NewtonWP, Morgan ZJ, Peterson LE. Racial/ethnic group trajectory differences in exam performance among us family medicine residents. Fam Med. 2022;54(3):184-192. doi: 10.22454/FamMed.2022.873033
2. Hansen-Strain L. Cognitive style and first language background in second language test performance. TESOL Q. 1987;21(3):565-569. https://doi.org/10.2307/3586505
3. Raymond MR, Ling Y, Grabovsky I. Investigating the performance of second language medical students on lengthy clinical vignettes. Eval Health Professions. 2017;40(2):151-158. https://doi.org/10.1177/0163278716672283
4. Eden AR, Bazemore A, Morgan ZJ, Jabbarpour Y. Family physicians increasingly deliver care in diverse languages. JABFM. 2022;35(1):5-6. https://doi.org/10.3122/jabfm.2022.01.210190
5. Mullane J, McKelvie SJ. Effects of removing the time limit on first and second language intelligence test performance. Practical Assess Res Eval. 2000;7(23, article). https://doi.org/10.7275/ph8y-yz89
6. Gomez LE, Bernet P. Diversity improves performance and outcomes. J Natl Med Assoc. 2019;111(4):383-392.
7. Society of Teachers of Family Medicine (STFM). 2020-2024 Strategic Plan. STFM. Accessed April 1, 2022. https://www.stfm.org/about/governance/strategicplan/#tab-11663

Authors' Reply

TO THE EDITOR:

We very much appreciate the thoughtful response to our article by Drs Westfall and Westfall. We would like to respond to what we consider the two main issues they raise: the importance of assessing English as a second language (ESL) impact on exam performance and whether exam performance is an adequate measure of residents' knowledge.

We agree with the commentators that the impact of ESL on exam performance is an important variable that should be evaluated for potential bias. Unfortunately, however, neither

international medical graduate (IMG) status nor language of care could serve as an adequate proxy measure for ESL. We cannot identify ESL students using IMG status because English is the first language for many IMG students, others use English as their primary educational or professional language,[1,2] and the US medical graduate (USMG) group includes ESL students.[3] Similarly, although American Board of Family Medicine (ABFM) collects information on the use of language other than English for care delivery, it does not reflect first language nor does it indicate fluency in any language. While physicians who indicate that they provide patient care in languages other than English could represent ESL physicians, it is also possible that they provide care in other languages with the help of an interpreter or translation technology.[4,5] More practically relevant to our article, this information is currently only collected from practicing physicians, not from residents, making it impossible to use for In-Training Examination (ITE) and initial Family Medicine Certification Exam (FMCE) analyses. ABFM advocates for the collection of more accurate data regarding physicians' primary language, along with other data that reflect diverse backgrounds,[4,6] so that more forms of bias can be identified and addressed.

The commentators furthermore suggest that performance on the ITE and FMCE is not an adequate measurement of resident knowledge. First of all, ABFM asserts that the FMCE scale (FMC-Scale) measures medical knowledge related to family medicine and clinical decision-making ability.[7,8] Both ITE and FMCE are built to this common FMC-Scale, which permits the longitudinal analysis conducted in our article to detect initial differences before residency and knowledge acquisition during residency.[9] This distinction helps to identify potential educational pipeline issues and promote individualized learning plans for residents who need additional help.[9,10] While a holistic approach is often described in terms of medical school and residency admissions, we endorse a broader approach to assessing knowledge, combining the breadth and flexibility of the ITE with specific assessments of knowledge while precepting, on hospital rounds or in labor and delivery. This is the promise of competency-based assessment,[11] and the ITE is an important component of this assessment strategy. Finally, and importantly, the exams (ITE and FMCE) are not intended as a measure of clinical skills, communication, professionalism, problem-based learning, or systems-based practices—the other ACGME core competencies, which residencies evaluate and track using the ACGME milestones.[12] The ABFM relies on residency clinical competency committees and the program director to attest whether residents are ready for autonomous practice or demonstrate other skills and competencies related to clinical practice, which are evaluated using other components to make the holistic decision about ABFM certification.[13]

ABFM welcomes additional collaborations with other organizations to advance health equity in family medicine.[14,15] Our article is an initial part of a larger systematic effort not only to describe and document the progression of medical knowledge acquisition of family medicine residents from diverse backgrounds but to address and intervene to promote health equity in multiple dimensions.[9,16,17] We appreciate the response to our article and the important issues it raises, and we share the hope that equity in residency education can be achieved in the future with collective efforts.

doi: 10.22454/FamMed.2022.954112

Ting Wang, PhD
Thomas R. O'Neill, PhD
Aimee R. Eden, PhD, MPH
Melina K. Taylor, PhD, MPH
Warren P. Newton, MD, MPH
Zachary J. Morgan, MS
Lars E. Peterson, MD, PhD
American Board of Family Medicine
Lexington, KY

References

1. The English-speaking countries. In: Castles FG, Pierson C. The Oxford Handbook of the Welfare State. Oxford University Press; 2010:chap 8.
2. Moreno G, Walker KO, Grumbach K. Self-reported fluency in non-English languages among physicians practicing in California. Fam Med. 2010;42(6):414.
3. Rubright JD, Jodoin M, Barone MA. Examining demographics, prior academic performance, and United States Medical Licensing Examination scores. Acad Med. 2019;94(3):364-370.
4. Anderson A. The need for expanding physician language diversity is too great to be left to chance. J Am Board Fam Med. 2022;35(1):200-202.
5. Eden AR, Bazemore A, Morgan ZJ, Jabbarpour Y. Family physicians increasingly deliver care in diverse languages. J Am Board Fam Med. 2022;35(1):5-6.
6. Eden AR, Jones DD, Bazemore AW, Jabbarpour Y. Informing equity & diversity in primary care policy and practice: introducing a new series of policy briefs, commentaries, and voices in JABFM. J Am Board Fam Med. 2022;35(1):190-196.
7. O'Neill TR, Newton WP, Brady JE, Spogen D. Using the Family Medicine Certification Longitudinal Assessment to make summative decisions. J Am Board Fam Med. 2019;32(6):951-953. doi:10.3122/jabfm.2019.06.190345

8. O'Neill TR, Li Z, Peabody MR, Lybarger M, Royal KD, Puffer JC. The predictive validity of ABFM's In-Training Examination. Fam Med. 2015;47(5):349-356.
9. Wang T, O'Neill T, Eden A, et al. Racial/ethnic group trajectory differences in exam performance among US family medicine residents. Fam Med. 2022;54(3):184-192. doi:10.22454/FamMed.2022.873033
10. Puffer JC, Peabody MR, O'Neill TR. Performance of graduating residents on the American Board of Family Medicine Certification Examination 2009–2016. J Am Board Fam Med . 2017;30(5):570-571. doi:10.3122/jabfm.2017.05.170065
11. Holmboe ES. The transformational path ahead: competency-based medical education in family medicine. Fam Med. 2021;53(7):583-589.
12. Holmboe ES, Edgar L, Hamstra S. The Milestones Guidebook. Accreditation Council for Graduate Medical Education; 2016.
13. Newton WP, Conry C, Bortz B, Baxley EG. The social contract, professionalism, and its assessment: the strategy of the ABFM going forward. Ann Fam Med. 2020;18(1):85-86.
14. Newton WP, Bazemore A, Magill M, Mitchell K, Peterson L, Phillips RL. The future of family medicine residency training is our future: a call for dialogue across our community. 2020;33(4):636-640. https://doi.org/10.3122/jabfm.2020.04.200275
15. Newton WP, Baxley E, Peterson LE, et al. How the ABFM will address health equity. Ann Fam Med. 2020;18(5):468-470. https://doi.org/10.1370/afm.2599
16. Newton WP. How should board certification evolve? J Am Board Fam Med. 2020;33(suppl):S1-S9.
17. Newton WP. President's message: committing to health equity. The Phoenix. January 19, 2022. https://www.theabfm.org/about/communications/newsletter/2022/january/january-2022-winter-edition

Residency Diversity Data Needed to Understand Reporting of Racism/Discrimination

TO THE EDITOR:

We applaud the efforts of Dr Potts and colleagues in the presentation of the data from the 2018 CERA study on reports of discrimination and training in family medicine residency programs.[1] We were impressed by the high response rate and the high percentage of programs with training or processes to address implicit bias and systemic racism and discrimination. The strong commitment of our majority White program directors to residents from underrepresented backgrounds shows how White privilege can be used to increase the diversity of residency programs.[2] At the same time, it is important to recognize that reports of discrimination and racism differ by individual experiences and identities, ie, a Black or Latinx resident is more likely to experience racism than a White resident. We would like to see the race/ethnic diversity of the residents and faculty of these programs with a comparison to reports of discrimination. This would add to the literature, especially if the finding was that overall program diversity was not associated with increased reporting of discrimination.

In the paper, the authors indicated that faculty was the group least likely to report discrimination. Although family medicine is the most diverse of all medical specialties,[3] the faculty, when compared to students, residents, and patients, was also the group with the least diversity. This validates the point that White groups experience discrimination less and therefore report it less. However, another finding that we would like to highlight is that where there was not training and/or processes in place, there was decreased reporting of discrimination. This should be a call to action to get reporting structures in place. As the adage goes, "We cannot improve upon that which we do not measure." Demographic information on the programs would be helpful to unpack this finding as well. Perhaps implementing programs to address racism and discrimination could help in the recruitment of underrepresented in medicine residents and faculty.

We celebrate that reporting of discrimination has been extended to the patients and that patients feel that they could hold their providers accountable for discrimination. This is a step forward. We are also cognizant, however, that residents and providers from marginalized groups, especially racial and ethnic minorities, can sometimes be the targets of racist acts by patients, and we should ensure the safety of our underrepresented employees in those circumstances.[4-6] This is a question that should be included for further study, as we continue to become more diverse as a specialty.

We add our voices to those of the authors in calling for the discovery of the most effective tools for reporting of discrimination and holding offenders accountable.[7] We are delighted to see what is already happening and hope to see more data collected from family medicine residencies that assist in identifying best practices that truly increase reporting and decrease incidents, making family medicine residencies a safe place for learners from all backgrounds.

doi: 10.22454/FamMed.2022.789311

Kaden Jordan
University of Utah School of Medicine
Salt Lake City, UT

Jose Rodriguez, MD
University of Utah Health Sciences Center
Salt Lake City, UT

References

1. Potts SE, McLean I, Saba GW, Moreno G, Edgoose J, Candib LM. Diversity and facing discrimination in family medicine residencies: a CERA survey of program directors. Fam Med. 2021;53(10):871-877. doi:10.22454/FamMed.2021.482291
2. Rodríguez JE, Tumin D, Campbell KM. Sharing the power of white privilege to catalyze positive change in academic medicine. J Racial Ethn Health Disparities. 2021;8(3):539-542. doi:10.1007/s40615-020-00947-9
3. Xierali IM, Nivet MA, Gaglioti AH, Liaw WR, Bazemore AW. Increasing family medicine faculty diversity still lags population trends. J Am Board Fam Med. 2017;30(1):100-103. doi:10.3122/jabfm.2017.01.160211
4. Rodríguez JE, Campbell KM, Pololi LH. Addressing disparities in academic medicine: what of the minority tax? BMC Med Educ. 2015;15(1):6. doi:10.1186/s12909-015-0290-9
5. Lane-Fall M. A piece of my mind. Accommodating bigotry. JAMA. 2014;311(2):139-40. doi:10.1001/jama.2013.283733
6. Amaechi O, Rodríguez JE. Minority Physicians Are Not Protected by Their White Coats. Fam Med. 09 2020;52(8):603. doi:10.22454/FamMed.2020.737963
7. Chung MP, Thang CK, Vermillion M, Fried JM, Uijtdehaage S. Exploring medical students' barriers to reporting mistreatment during clerkships: a qualitative study. Med Educ Online. Dec 2018;23(1):1478170. doi:10.1080/10872981.2018.1478170