COMMENTARY

Support Physicians Who Identify as Underrepresented Minorities—But All Physicians Should Care for Vulnerable Populations

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Family physicians who identify as underrepresented minorities are more likely to have a larger percentage of vulnerable patients in their panels. This trend holds true for other medical specialties where data are available.[1,2] In addition, family physicians comprise the largest segment of physicians working in community health centers, the largest safety net primary care system in the US,[3] and physicians who identify as underrepresented minorities (PURM) are overrepresented in these safety net settings.

Patient preference, practice accessibility, practice culture, and a whole host of complex issues influence why physicians who identify as underrepresented minorities (PURM) serve proportionately more vulnerable patients.

Patients often seek clinicians and practices that reflect their race, ethnicity, culture, and language. Studies show higher patient satisfaction and treatment adherence when there is racial/ethnic congruence.[4] Patients with limited English proficiency search for clinicians that speak their language. For example, Asian-serving health centers such as Charles B. Wang Community Health Center in New York City frequently see patients traversing several states to be served by clinicians and staff that speak their language.

Similarly, other marginalized populations like sexual and gender minority groups will travel to seek out more welcoming and inclusive settings.[5] I was told by a case worker that one of the clinics in which I worked previously was unwelcoming for transgender sex workers, and that they would travel to clinics much further away. Despite outreach and practice change, improving the clinic's reputation was difficult.

Physician factors include locations of practice accessible to vulnerable populations. Studies have shown that minority physicians are more likely than their counterparts to work in underserved communities and care for minority, poor, and uninsured patients.[6] Data from the Health Resources and Services Administration's (HRSA) National Health Service Corps (NHSC) which offers scholarships and loan repayment in exchange for service in underserved settings show that Black or African American physicians represented 13.6% of the participants, exceeding their 5% share in the national physician workforce, and Hispanic or Latino physicians represented 18.2% of participants compared with their 5.8% representation.[7] HRSA data also show that half of all NHSC participants work in community health centers, and 86% of alumni of NHSC programs continue to work in a HPSA or in the same community.

Finally, PURMs may create a more welcoming environment for vulnerable patients in part because many share the experiences of marginalization and hardship. Black, Latino, and Native Americans have the highest rate of receiving Pell grants for low-income students,[8] and graduate from medical school with more debt. Giving back to their community is a common reason for PURMs to care for vulnerable populations.

To increase the underrepresented minority groups going into medicine, many colleges and universities have pipeline programs. Some medical pipeline programs start in high school and earlier. Other

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programs target financial barriers such as educational debt such as the NHSC.

Creating and supporting the pipeline for more PURMs and increasing access points for vulnerable populations is important but not sufficient in a system where care for vulnerable communities is accessible only in limited locations or is gated by racial, financial, cultural, and linguistic barriers.

Creating an inclusive and welcoming practice requires all clinicians to feel comfortable and well-equipped to serve everyone. A simple and key strategy would be to ensure that all clinicians serve vulnerable populations and work in underserved settings during their training. In addition to making everyone more comfortable treating patients, residents who train in underserved settings remain in that setting. Family physicians trained in community health centers (CHC) were almost twice as likely to work in underserved settings than their non-CHC-trained counterparts.[9] This and other findings led to the creation of a HRSA initiative called the Teaching Health Center Program (THC) that provided graduate medical education funds to community-based training sites such as CHCs. In 2021, through the American Rescue Plan, Congress authorized expanded funding to support THCs, create new community-based primary care residency programs, and expand the number of resident positions.

Beyond formal THC programs, more than 14,000 CHC sites exist across the US, and all training programs should partner with CHCs. Trainees should be exposed to specific settings such as health care for the homeless programs and migrant health centers that treat some of the most vulnerable groups. Urban academic programs should ensure rural rotations that include Indian Health Service clinics and rural critical access hospitals.

Increasing the number of PURM and achieving racial and ethnic parity of our physician workforce is important. Caring for vulnerable populations, however, should be routine and expected in a country where a third of the nation's population earn less than 200% of the federal poverty level, and over a third identify as belonging to a racial or ethnic group other than White. Although universal health insurance coverage and increasing public insurance reimbursement rates to the level of employer-based insurance will likely lead to the most significant improvement in care access for vulnerable populations, it will not be enough. Practices must be more inclusive and welcoming everywhere, especially since by most estimates no single racial or ethnic group will be a majority by 2050. Relying on PURMs to care for vulnerable populations is insufficient and may cause worsening segregation of care. There is an abundance of experts, models, and programs for any practice to get started on creating a diverse and inclusive practice.

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