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From the Editor

Symmetric Discordance

The journal editor introduces a theme issue on the challenges and opportunities faced by physicians caring for an increasingly diverse patient population.

In 1973 and 1974, Alan Bakke applied to the University of California at Davis School of Medicine but was denied admission. Believing that less qualified minority applicants had been accepted, Mr. Bakke decided to contest the school's admissions policy in court. The US Supreme Court's decision that followed led to the current legal framework, which guides admission policies in institutions of higher learning. In 1978 the Court ruled in *Regents of the University of California v Bakke* that the UC Davis admissions process was unconstitutional because it used a fixed quota to set aside a portion of each entering class for underrepresented minority applicants. While the Court struck down the quota system as a violation of the Equal Protection Clause of the 14th Amendment that guarantees equal treatment under the law, it upheld the use of race or ethnicity as 1 of many factors that institutions of higher learning could consider in selecting qualified candidates.

Recent federal district court rulings have also taken up the issue of race in higher education, prompting the Supreme Court to revisit their landmark 1978 decision. Earlier this year, the Court heard arguments and is soon expected to rule on a case brought by applicants to the University of Michigan law school and its undergraduate college. Once again, these plaintiffs charge that the University of Michigan unfairly denied them admission in favor of less qualified minority applicants. According to most Court observers, the decision will have widespread impact on institutions of higher education including medical schools.

Proponents of considering race and ethnicity as factors in medical school admissions often cite the importance of a diverse physician workforce in light of an increasingly diverse patient population. They argue, for example, that minority physicians are more likely to work in underserved minority communities, and minority patients are more comfortable and satisfied with minority physicians. The concept of patient-physician concordance that underlies this particular argument for more minority physicians is fundamentally impractical and ethically questionable.

While there are other valid reasons to increase minority representation in higher education including medical school, I do not believe that "symmetric concordance" (eg, the matching of Hispanic patients with Hispanic physicians) is justified. On a practical level, individuals in our society are free to live and work where they please, and it would be naïve to think that we can create communities where symmetric concordance between patients and physicians can exist. Even if we could manufacture these concordant clinical encounters, where would we draw the line on the list of characteristics that must match before we declared that concordance between patient and physician had been met?

From an ethical perspective, it is too convenient for medical educators and physicians to say that one cannot learn to care for a patient that looks different from and speaks a different language than the caregiver. As professionals, we have to develop and cultivate skills and abilities that allow us to competently and compassionately care for whomever may walk into our offices. As physicians, we must understand the importance and value of creating therapeutic symmetry with our patients especially when we are discordant racially, ethnically, religiously, and perhaps socially.

In this issue of *Virtual Mentor*, we focus on the various challenges and thus opportunities that confront physicians when caring for an increasingly diverse patient population. The learning objectives in this month's issue are:

1. Understand the "concordance" theory, (care for culturally diverse populations demands culturally diverse caregivers), and its critique.
2. Recognize benefits to patients and physicians of culturally responsive care.
3. Recognize the contributors to disparities in use of health services.
4. Learn what physicians can do to improve communication with patients from cultures different from their own.
5. Recognize the role of low health literacy in poor patient compliance and poor health outcomes.

My best,