

Diversity Goals in Medicine: It's Time to Stop Talking and Start Walking

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Health disparities and the lack of diversity in the health workforce are two separate but related issues. Health disparities are more properly termed inequities when they are remediable, such as those due to race, ethnicity, gender, geographic location, and socioeconomic status. This is in contrast to disparities resulting from age, which we cannot remedy with current knowledge. Inequities due to race and ethnicity have multiple causes, including racism and discrimination, lack of socioeconomic opportunity, poor educational opportunity, the generational persistence of wealth or poverty, the lack of access to health and medical care, and the multiplier effect of all of these together.

Health care is not the most important determinant of health,¹ but we still have to address inequities in its availability to different populations. Limited access to health care means that conditions that can be prevented, or diagnosed and treated early in their course, may progress to a more serious state, resulting in the need for more extensive care, greater morbidity, and premature mortality. However, improving access to health care in itself is insufficient to correct inequities in health status. We must make major efforts to ameliorate conditions such as inadequate housing, nutrition, education, and opportunity to earn an adequate living (the “social determinants of health”).

Lack of diversity in the health workforce, as documented by Rodriguez et al in this issue of *Family Medicine*,² is a reflection of the same characteristics of health inequities. The same groups that have poorer health status—racial and ethnic minorities and low-income and rural populations—are also seriously underrepresented in the health professions,

especially medicine. This is important in three ways. First, physicians are more likely to care for people from similar backgrounds to their own. Komaromy et al have shown that minority physicians are more likely to care for people from those groups and work in underserved inner-city areas; even when controlling for socioeconomic status, racial and ethnic minorities have less access to physicians.³ Multiple studies have demonstrated that physicians who have grown up in rural areas are more likely to practice in these underserved areas. Conversely, the fact that the vast majority of physicians are from upper-income families, of European and Asian descent, and from the suburbs of major metropolitan areas, mean that those populations and communities are relatively “over”-served, with greatly disproportionate access to health care services. Minority populations are growing, both in absolute numbers and in percent of population, while as Rodriguez and colleagues point out, those underrepresented in medicine (URRM) have barely kept up with population growth (Latinos) or decreased (African-Americans and Native Americans).

The second reason diversity in medicine is important is that it produces a more competent and effective workforce overall. People do not know what they do not know, and the limited experiences of medical students recruited from a very narrow slice of the population can result in major “blind spots.” Sitting next to and studying with students who are from very different backgrounds from yours, particularly when those backgrounds are more similar to many of those being served (especially the underserved), can help students from more privileged backgrounds.⁴ They are more likely to

question the assumptions they make and realize that the reality they know is not necessarily the reality everyone faces. The third reason diversity is important is that it creates a real opportunity for members of URRM groups to advance themselves and their families by moving to a higher socioeconomic and social status. Becoming a physician can allow people from poor and middle-class backgrounds to make a significant jump in their status and income, with a major impact on future generations.

Despite these compelling interests, and efforts that have been going on for decades to increase the number of students and faculty from underrepresented minority groups, such as the major “3000 by 2000” effort of the AAMC begun in the 1990s,⁵ we have not been very successful. Rodriguez and colleagues point out that African-American enrollment in medical school peaked at 8.1% in 1994! As bad as student diversity is, faculty diversity is worse. As Rodriguez and colleagues demonstrate, URRM faculty in academic medicine has increased only from 7% to 8% from 1993–2013, while these groups’ percent of the US population has increased from 23.1% to 31.4%. In addition to all of the reasons that have been described, faculty diversity is important because it provides role models and mentors for minority students, residents, and junior faculty.

Our efforts to date have been worse than grossly inadequate. Every system is perfectly designed to get the results that it gets,⁶ and our system is not designed to achieve the goal of a diverse workforce. Continuing to do the same things we have been doing more assiduously will not solve the problems of either health inequity or workforce diversity problem. We need dramatic changes in the criteria for selecting medical students, training physicians, and hiring faculty. Criteria unrelated to performance as a physician (eg, success on

multiple-choice tests, coming from a physician family, etc) should be abandoned as explicit criteria for admission. Characteristics associated with a greater likelihood of meeting the health needs of the underserved (since the others are served) should be emphasized as essential requirements for medical school. Physicians from groups underrepresented in medicine need to be nurtured and prevented from being pigeonholed or marginalized. The process should be data driven but requires agreement on where we want to go. Only processes that will take us there are appropriate.

The time is now, only because the time should have been long ago. Next year, the faculties of our medical schools should look a little more diverse than they are now, and in a decade very much more diverse. These efforts cannot cease until we have a workforce that looks like America.

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