

# The Case for Diversity in Academic Internal Medicine

The Association of Professors of Medicine (APM) is committed to ensuring that departments of internal medicine fulfill their tripartite mission of educating the next generation of physicians and other health care professionals, conducting groundbreaking research, and providing excellent patient care. Increasing racial and ethnic diversity within these departments is integral to achieving this mission. Chairs of departments of internal medicine and other leaders in academic medicine must take specific steps to increase diversity among students, residents, fellows, and faculty, not only because it is “the right thing to do,” but because it is “the smart thing to do” (1).

## INTRODUCTION

Ethnic disparities in health care and in the medical profession itself inflict serious adverse consequences on U.S. society. Despite scientific advancements, health care disparities persist between ethnic or racial minorities and people of European descent (European Americans) who numerically make up the majority of the population (2). For almost every indicator of health collected by U.S. government agencies, there are systematic differences in the quality and quantity of medical care received by minorities compared with European Americans, even when factored for income, insurance, and preference (3–8). Disproportionately low representation of minorities in the medical profession compared with their representation in the U.S. population contributes to health care disparities (8). Particularly among physicians, a largely homogeneous provider workforce is caring for an increasingly diverse population. Poorer health outcomes experienced by minorities result in greater morbidity and mortality, as well as lost wages, compromised ability to contribute optimally to society, and substantial societal costs for this excess disease burden (8).

In the early 1990s, the APM endorsed the efforts of the Association of American Medical Colleges (AAMC) to increase representation of minorities in the medical profession (9). The AAMC recognized four groups that were historically barred from entering the medical profession by overt and covert discrimination (10): African Americans, Mexican Americans, Native Ameri-

cans (i.e., American Indians, Alaska Natives, and Native Hawaiians), and mainland Puerto Ricans. The AAMC referred to these groups as “underrepresented minorities” and acknowledged that continued underrepresentation is due in part to vestiges of discriminatory treatment.

Recently, the AAMC revised its definition of underrepresented minorities to mean “underrepresented in medicine”—defined as “those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population” (11). The APM supports this change in definition. However, data in this paper reflect the earlier AAMC definition unless otherwise indicated.

Because earlier efforts to increase enrollment of underrepresented minorities in U.S. medical schools were only partially successful (minority enrollment increased from 4.8% in 1970 to 10.9% in 1990 [8]), the AAMC launched a new program in 1994 entitled “3000 by 2000” (12). The goal of this program was to double the enrollment of minorities by the year 2000 (12). Although the program failed to reach its goal, these efforts helped to increase minority enrollment to more than 12% by 1995 (13).

Unfortunately, the efforts that yielded these welcomed gains faced severe and continuing challenges that have contributed to a sharp decline in minority matriculants since 1995 (13) that has continued despite the increase of minorities as a proportion of the U.S. population (now approximately 28% and projected to increase substantially by the year 2010) (14). In addition, minority representation is less than 8% for physicians and less than 7% for internal medicine faculty (15). There is also less interest in academic medicine among minorities compared with nonminority trainees, and transition rates for minorities to advanced faculty ranks are decidedly lower (16). These circumstances and negative trends translate into too few “culturally competent” minority and nonminority physicians who are dedicated to caring for minorities, teaching minority and nonminority students, and conducting medical research relevant to illnesses that disproportionately afflict minorities.

## BENEFITS OF DIVERSITY IN ACADEMIC MEDICINE

Diversity enhances the ability of academic medicine to achieve its tripartite mission. First, it improves medical education by contributing to “cultural competence”, defined by an awareness and appreciation of cultural differences among racial or ethnic groups. Cultural competence in minority and nonminority providers helps promote more effective health care delivery to a diverse patient population (13). Second, diversity in the academic environment promotes research that is inclusive of the needs and concerns of minority groups (13). Third, greater minority representation among practicing physicians improves the care delivered to minority and medically underserved groups.

Adequate efforts among students and faculty to reflect the diversity in the United States are important for quality medical education (13). The gap between the minority population and minority student participation in the health professions has widened in recent years (17). Although further research is needed, the APM is inclined to support the position that a student body with greater minority representation enhances the learning experience for the individual student—leading to better educated, more culturally competent physicians and to better quality care for minority patients (18). In addition, such an increase in minority student representation in medicine must include initiatives to retain them (19).

Research is also needed regarding current minority representation in residency training programs and the effects of minority representation on medical education. The low numbers of minorities among medical students and faculty suggest that residencies are similarly afflicted. Because residents play critical roles in the education of medical students, it is anticipated that greater minority representation among resident and fellow trainees will enhance cultural competence among students.

Having a diverse faculty in departments of internal medicine is highly valuable to achieving the goals of providing quality medical education, delivering high quality care, and pursuing research that addresses the health concerns of all members of society (13). Minority representation among faculty brings needed cultural sensitivity to medical education and helps nonminority faculty become aware of and appropriately sensitive to these important issues of patient care.

Despite current advances, many unresolved health problems plague people in the United States and are especially prevalent within minority populations, among whom there is a dearth of investigators. Increasing the diversity of the research workforce with improved recruitment and retention of minority students can accelerate advances in medical and public health research (13).

There is an alarming lack of minority physicians pur-

suing clinical research careers. For example, of 95,691 total medical school faculty in the United States, 72,596 are white, 2,745 are African American, 425 are Mexican American, and 741 are Puerto Rican (15). About 16% of all African American medical school faculty members nationwide teach at the three historically African American institutions (20). Consequently, African Americans make up only 2.2% of the faculty at institutions historically composed of European Americans.

It is difficult to recruit adequate numbers of underrepresented minorities as subjects in clinical trials, particularly where diverse study populations are necessary (21). This difficulty is likely multifactorial, but low numbers of minority investigators and mistrust of clinical research are apparent contributors. Achieving greater diversity among investigators would broaden the research agenda and increase the likelihood that there will be a different focus and approach to the problems unique to these communities (13,22). The striking success of the African American Study of Kidney Disease trial, which included minority primary investigators and emphasized using minority study coordinators, supports these assertions (21).

Leaders in academic medicine must implement successful strategies, including effective training and mentorship, early in the careers of minority physicians to attract them to an investigative career. Approximately 75% of current minority faculty are assistant professors or instructors (20). The small numbers of minority faculty demand considerable institutional commitment to ensure high retention rates. A survey of full-time faculty of 24 nonminority medical schools showed that minority faculty were less satisfied overall with their careers, even though there was no significant difference in adjusted compensation (1). In addition, minority faculty spent more time in patient care and less in research than did their nonminority colleagues and also had a substantially lower opportunity for promotion even after adjustments for cohort, sex, degree, tenure, department, type of medical school, and funding from the National Institutes of Health (23). This disparity in promotion is a disincentive for the recruitment and retention of minority faculty.

Because of the importance of interpersonal relationships, mentoring is facilitated when the mentor is sensitive to the ethnic or racial background of the mentee. The low minority representation on faculties of U.S. medical schools limits both the number of minority faculty available to mentor and the appropriate sensitization of nonminority faculty that is necessary to make them effective mentors for minority trainees and junior faculty. The low minority faculty numbers and their proportionately low representation among senior faculty (15,24) result in a shortage of minority mentors for trainees contemplating an academic career and for junior faculty seeking advancement to more senior levels.

Increasing the diversity of the physician workforce will improve access to health care for underserved populations (13). A recent Institute of Medicine (IOM) report suggests that bias, prejudice, and stereotyping by health care providers may contribute to differences in care (25). This report revealed that minority patients are less likely to receive needed services, including clinically necessary procedures, even when they have similar health insurance and ability to pay. Moreover, the report suggested that racial differences in patients' attitudes, such as preferences for treatment, did not vary significantly and did not adequately explain health care disparities.

Many areas in the United States remain underserved, particularly communities predominantly made up of minorities (18). It has been projected that to close this gap and reach a level of physician availability for each minority group similar to the level in nonminority communities requires that the number of first-year residents from underrepresented minority communities dramatically increase (18,26). Although circumstances have improved, many nonminority physicians will not work in underserved communities and are not willing to see patients from minority groups (18,26). Conversely, a high proportion of minority physicians choose to work in underserved communities and practice predominantly in metropolitan areas (13,18,26–34).

One study identified four independent predictors of the likelihood that a physician will provide care to underserved populations (35), and these predictors generally can be identified at the time of admission to medical school: being a member of an underserved ethnic or minority group, having participated in the National Health Service Corps, having a strong interest in practicing in an underserved area prior to attending medical school, and growing up in an underserved area.

Minority physicians are more likely to care for a higher proportion of patients who are from their own ethnic or racial groups, who are medically indigent, and who need more medical attention (18,28,30,32,33,36). Similarly, minority patients are more likely to receive care from minority physicians (18,36). According to the 1987 National Medical Expenditure Survey, minority patients were five times more likely to have a minority physician as their regular doctor, with Latinos at 19 times the national average (37). Several studies show that the ethnic or racial concordance between physicians and patients cannot be explained by socioeconomic status, access to the health care system, health insurance status, physician sex, specialty, language, how recently the physicians were trained, workplace setting, region of the country, or urbanicity (18,36,37).

Increasing the diversity of the physician workforce will enhance culturally competent care and reduce the disparities in health care for underserved populations (13). Ethnic or racial differences between physicians and patients

are often barriers to optimal patient-physician communication and partnership (38). Both African- and European American patients are more likely to feel a part of their care when they and their doctors are of the same ethnic or racial background (38). Furthermore, minorities are substantially more likely than nonminorities to perceive that the quality of care they receive is influenced by having a physician from their own ethnic or racial group (2). Nevertheless, because of the low level of diversity, minority patients are far less likely to have a minority physician.

## POTENTIAL CHALLENGES TO ACHIEVING DIVERSITY IN ACADEMIC MEDICINE

The current climate of medical practice is likely a disincentive for minority students to choose medicine as a career, considering that they already face a more difficult road in becoming a physician (12). Minority physicians are more likely to choose underserved areas in which to practice and to see more minority patients (37). In addition, minority patients are five times more likely to choose a minority physician as their regular doctor (37). Such practices tend to be more challenging, increasing the risk for career dissatisfaction.

Despite the low minority representation on medical school faculties, recruitment programs for minority housestaff with an emphasis on diversity are absent in most institutions. In a survey of pediatric chief residents in 78 U.S. training programs, 71% reported no defined minority recruitment goals and 77% reported that recruitment efforts were the same toward minority and nonminority groups (39). In orthopedics, the minority proportion has remained unchanged for 12 years (40).

The low number of minorities on medical school faculties limits the number of minority mentors available for students, residents, fellows, and younger faculty. In a 1998 survey of obstetrics and gynecology residents, a plurality of nonminority residents believed that nonminority residents were more likely to be preferentially recruited and to receive helpful advice (39). Interest in pursuing an academic career decreased through the years of residency. Overall, mentoring was felt to be inadequate. The authors concluded, "the perception of minority residents that they received less positive and even biased mentoring during their training creates a barrier to their consideration of academic careers" (41).

A survey by the American College of Obstetrics and Gynecology of fellows' attitudes about academic medicine revealed that reasons for not choosing or for leaving academic medicine included viewing academia as "too bureaucratic"; desiring more personal or family time; and having no interest in writing grants, doing research, or

writing publications. The number of minority fellows in this sample was too small for separate analysis (41). Minority faculty are less satisfied with their academic careers even when they receive comparable financial compensation (42).

Affirmative action in higher education means that institutions give advantage in the admissions process to minority applicants who in the past had been overtly and systematically excluded. This initiative allows minority trainees to matriculate on their own merits once admitted. Failure to take ethnicity or race into account in the medical school admissions process would reduce the percentage of minority matriculants from the current level of approximately 12% (less than half of their proportion in the population) to 3% (less than before the civil rights movement in the 1960s) (13).

Nevertheless, affirmative action in the admission process has been challenged as unfair to nonminority applicants in that they are denied admission based in part on ethnicity or race. These challenges to affirmative action are based in large part on the assertion that admitting minority applicants with lower academic credentials—typically measured by grade point average and Medical College Admission Test scores—leads to denial of admission to “more qualified” nonminority candidates. This assertion is supported by the fact that a higher proportion of minority than nonminority students will not graduate from medical school or will take longer to do so (13). In 2003, the U.S. Supreme Court, in its review of two cases against the University of Michigan, ruled in *Grutter v. Bollinger* that the law school’s affirmative action program was constitutional, thereby reaffirming its finding in the *Bakke* decision that the state has a compelling interest in assuring racial diversity (43,44).

Despite this latest Supreme Court ruling, opponents of affirmative action vow to continue fighting and note that the Court also opined that “enshrining a permanent justification of racial preferences would offend [the] equal protection principle” of the Constitution (45). Supreme Court Justice Sandra Day O’Connor speculated, “25 years from now, the use of racial preferences will no longer be necessary to further the interest approved today.” For this to become true in academic medicine, *current* chairs of medicine must take ownership of the effort to improve the recruitment and retention of minority students, residents, fellows, and faculty in their department of internal medicine.

The APM is sensitive to the tension created by the simultaneous goals of preserving individual rights and pursuing effective initiatives to increase minority representation in academic internal medicine. Nevertheless, it recognizes that increasing minority student, resident, fellow, and faculty representation will benefit the execution of its tripartite mission. Consequently, the APM strongly supports the use of all legally permissible strategies to

achieve this goal, while recognizing that each such tactic must be fully integrated into efforts to recruit the highest quality students, residents, fellows, and faculty. The Association will promote currently effective strategies to increase minority representation and advocate for the identification of new approaches (46).

## CONCLUSIONS

People expect to receive the best care available when they enter the doctor’s office, emergency room, or hospital. This belief presumes that societal institutions will work to remove every barrier a patient faces when attempting to access the nation’s health care system for prevention, diagnosis, and treatment. Although health equity remains a much discussed ideal, it has not found true resonance or support with the U.S. public (47). As has been shown, underrepresentation of minorities in the health professions contributes to the inequities that exist in U.S. medicine. Resolving the racial and ethnic disparities in the health professions requires confronting fundamental social inequities in educational and life opportunities in the United States (46).

The APM remains committed to promoting appropriate and effective mechanisms to increase minority representation in academic medicine as a means of successfully achieving the tripartite mission of education, research, and patient care. Chairs of medicine must not complacently accept the dearth and differential treatment of minority students, residents, fellows, and faculty in their departments and the broader medical profession. The APM Diversity Task Force has, with the support of the APM Board of Directors, made this case for diversity on behalf of the association. As the next step in the process, the task force has developed initial recommendations by which the Association’s members might increase diversity in departments of internal medicine. The APM invites its members and other concerned participants in academic medicine to review these proposals (available on the APM website at [www.im.org/apm/diversity](http://www.im.org/apm/diversity)) and offer feedback as the association works to develop final recommendations. *The APM will publish these recommendations in The American Journal of Medicine next year.*

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