



Enhancing the Diversity of the Pediatrician Workforce

Committee on Pediatric Workforce

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

ABSTRACT

This policy statement describes the key issues related to diversity within the pediatrician and health care workforce to identify barriers to enhancing diversity and offer policy recommendations to overcome these barriers in the future. The statement addresses topics such as health disparities, affirmative action, recent policy developments and reports on workforce diversity, and research on patient and provider diversity. It also broadens the discussion of diversity beyond the traditional realms of race and ethnicity to include cultural attributes that may have an effect on the quality of health care. Although workforce diversity is related to the provision of culturally effective pediatric care, it is a discrete issue that merits separate discussion and policy formulation. At the heart of this policy-driven action are multiorganizational and multispecialty collaborations designed to address substantive educational, financial, organizational, and other barriers to improved workforce diversity.

A LONG-STANDING COMMITMENT TO WORKFORCE DIVERSITY

The American Academy of Pediatrics (AAP) has a distinguished history of promoting diversity within the pediatrician workforce. Of particular note is the *Report of the AAP Task Force on Minority Children's Access to Pediatric Care*,¹ which promulgated 66 recommendations covering a wide range of topics, from the health status of minority children to barriers to accessing pediatric care and workforce needs. Racial and ethnic diversity was also a major issue addressed by the report of the Task Force on the Future of Pediatric Education II (FOPE II),² which called for increases in the percentage of underrepresented minority pediatricians in practice and academic medicine to meet the needs of the ever-growing population of minority children. Recognizing the need for a more comprehensive policy to address the interrelated topics of patient and workforce diversity, the AAP also published 2 companion policy statements: "Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy"³ (revision of a previous policy statement⁴) and "Enhancing the Racial and Ethnic Diversity of the Pediatric Workforce."⁵ Over time, however, the focus of public policy discussions about patient and provider diversity has expanded beyond the traditional domains of race and ethnicity to include other attributes such as language, religion, health literacy, and sexual orientation.⁶ Unfortunately, few data on these other attributes exist, which limits the evidence that can be applied to policy analyses, such as this one, that examine the relationship between workforce diversity and the quality of health care services.

AAP policy statements and task force reports have been used to articulate the

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Key Words

diversity, race, ethnicity, culturally effective care, workforce

Abbreviations

AAP—American Academy of Pediatrics
COGME—Council on Graduate Medical Education
AAMC—Association of American Medical Colleges

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support of the AAP for increasing workforce diversity to a wide range of stakeholders in the health care community. This community includes, but is not limited to, legislators, policy makers, medical and specialty organizations, educators, payers, and patients. At the national level, the AAP has worked with federal bodies, such as the Council on Graduate Medical Education (COGME) and the Advisory Committee on Training in Primary Care Medicine and Dentistry, as well as national medical and specialty societies, including the American Medical Association, the Association of American Medical Colleges (AAMC), the American Academy of Family Physicians, the National Hispanic Medical Association, and the National Medical Association. AAP policy has been the basis of testimony, official communiqués, and collaboration with these and other national organizations, AAP state chapters, state legislators, and state medical societies. The AAP particularly values its work on the Health Professionals for Diversity Coalition, the AAMC revision of its definition of underrepresented minorities, and the amicus brief in support of the University of Michigan's affirmative-action policies.

THE CASE FOR WORKFORCE DIVERSITY

Recent literature in support of the Supreme Court decisions related to the University of Michigan's affirmative-action policies have strongly stated the case for diversity at all levels of medical education. A more diverse faculty and student body is viewed as an indispensable component of quality medical education. It will also increase the cultural exposure of all faculty and students, which will help to dispel stereotypes and improve cultural competence by virtue of everyday interactions. A more diverse workforce will likely lead to a more diverse medical research agenda for improving health and the delivery of health care services among racial, ethnic, and cultural minority patients. Creating such a workforce, it is posited, begins with the diversity of those admitted to MD and PhD educational programs. Indeed, in a modern multicultural society, promoting diversity within the medical profession to better reflect the diversity of the patient population while maintaining the high quality of the health care workforce is in keeping with the societal obligation of medical schools to produce well-trained professionals to meet the future health care needs of the country.⁷

Perhaps the most compelling evidence in support of increased workforce diversity is that physicians from underrepresented minority groups disproportionately practice in underserved communities and treat a greater number of underrepresented minority, Medicaid, and uninsured patients.⁶⁻⁹ However, it is vital that research be undertaken to determine if these practice patterns arise from an inclination to care for underserved patients or from limited practice opportunities elsewhere for minority physicians as a result of direct or indirect discrim-

ination. Whatever the reason for these practice patterns, the contributions of the minority physician workforce to the care of underserved patients are significant. Numerous studies have demonstrated that underserved and minority patients suffer from significant health disparities and experience more barriers to accessing health care services than well-served patients. In addition, recent research has suggested that patient satisfaction and compliance with treatment seems better when the treating physician is racially or ethnically concordant with the patient, although such concordance between patient and provider is relatively infrequent.^{10,11} Thus, access to care and quality of care for underrepresented minority patients are improved when the provider and the patient are racially or ethnically concordant.^{6,10}

The AAP supports the freedom of pediatricians to choose careers that are rewarding to them, including careers in which there may be little or no racial, ethnic, or cultural concordance between patients and the pediatrician. Likewise, the AAP supports the opportunity for patients and parents to seek care from a pediatrician with whom he or she is racially, ethnically, or culturally concordant. Patient-pediatrician concordance, when it occurs, can have a positive effect on patient care, and yet the AAP affirms that all who provide health care services need to be educated to deliver culturally effective care to all patients regardless of each provider's racial, ethnic, or cultural attributes. Training in the provision of culturally effective health care, although important to the overall goal of improving patient care, is not a substitute for increasing the diversity of the health care workforce.

THE CASE FOR A BROAD DEFINITION OF DIVERSITY

Since the publication of the previous edition of this policy statement in 2000, the discussion of patient diversity by the medical community has increasingly expanded beyond the traditional attributes of race and ethnicity to include cultural characteristics such as language, national origin, religion, sexual orientation, and physical disability.⁶ A broader and more inclusive definition of patient diversity, consequently, requires an expansion of diversity beyond race and ethnicity within the pediatrician workforce as well. The AAP believes that it is important for the organization to take a leading role in applying this expanded definition to the health care workforce to influence future policy deliberations on workforce diversity.

The arguments in the previous section that linked enhanced workforce diversity to higher patient satisfaction and trust and increased care to racial and ethnic minority patients seem to pertain also to the case of cultural minority patients. Although research is less robust in this area, data suggest that cultural minority patients are likely to have better health outcomes when cared for by physicians and health care providers who share their cultural attributes. For example, the medical

literature has shown that problems in communication and trust arising from differences between the physician's and the patient's language, religious norms, and cultural understandings of health and medical treatment can have an adverse effect on patient-care outcomes.¹²⁻¹⁴ These data highlight the importance of expanding data systems to collect workforce data for other cultural minority groups to track minority-recruitment efforts, workforce supply, and the effect of enhanced workforce diversity on patient-care outcomes for these groups.

Despite the dearth of data related to cultural minorities, data on racial and ethnic minorities clearly indicate that the number of individuals from these minority groups entering the physician workforce continues to be small despite the efforts of medical associations and others committed to enhancing the diversity of the physician workforce. According to the American Medical Association Masterfile in 2003, only 12.3% of physicians whose race or ethnicity is known belong to an underrepresented racial or ethnic minority group (black, American Indian, and Hispanic).¹⁵ This percentage is approximately half the rate projected by the US Census Bureau for the general population in 2005, which is currently 25.8% for these groups and is projected to grow considerably in the years ahead.¹⁶ Therefore, even minority physicians who share some personal attributes with their patients in underserved areas will likely care for an increasingly diverse patient population, including members of other minority groups.¹⁷

RECENT POLICY DEVELOPMENTS RELATED TO HEALTH CARE WORKFORCE DIVERSITY

In recent years, affirmative-action policies in the United States, especially in higher education, have experienced legal and judicial threats. Indeed, research has demonstrated that the reversal of affirmative-action policies in California, Texas, Mississippi, and Louisiana led to a decrease in minority medical school enrollment in those states.¹⁸ The adverse repercussions of regressive affirmative-action policy on minority physician supply received attention in the mid-1990s as part of the landmark cases of *Grutter v Bollinger et al* (1997) and *Gratz et al v Bollinger et al* (1995). The US Supreme Court ruled on June 23, 2003, that the University of Michigan's affirmative-action admissions policies for its law school and undergraduate school were permissible, as had been argued in the amicus brief issued by the AAMC and supported by the AAP. The court argued in its opinion that the benefits resulting from a diverse student body may constitute a compelling interest to justify admissions policies that are race and ethnicity conscious. The scope of the ruling was clearly understood to apply to medical schools and other public and private institutions of higher learning that receive federal funds.¹⁹

Proponents of affirmative action and workforce diversity heralded the Supreme Court's judgment in the 2

University of Michigan cases as an important step forward. Enhancing the diversity of the health care workforce, however, continues to be a formidable challenge, despite this legal victory and increased attention by the medical community and policy makers. Indeed, concerns about the difficulty of recruiting underrepresented minority students into medicine have generated a number of recent policy reports and initiatives that merit brief discussion. In 2004, the COGME conducted an evaluation of health care workforce diversity²⁰ to determine what progress had occurred since the publication of its twelfth report, *Minorities in Medicine*,²¹ in 1998. The COGME concluded that continued low rates of high school completion and failure to enroll in and graduate from college are the most significant barriers to the entry of underrepresented minority students into medicine. Among its many recommendations, the COGME report focused on addressing barriers related to low family income of underrepresented minority students and lack of success in early education.²⁰

Many of the COGME's concerns were also shared by the Institute of Medicine, which issued its own report in 2004 on workforce diversity, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*. Unlike the COGME report, which identified problems in early education as the key barrier to workforce diversity, the Institute of Medicine report emphasized the importance of making changes within health-profession-education programs and institutions to improve diversity. These changes include incorporating the concept of diversity into institutional accreditation criteria, recruitment of minority faculty for admissions committees, faculty-development programming, research and data collection, and outcomes evaluation.²²

The Sullivan Commission on Diversity in the Health-care Workforce, named for former US Secretary of Health and Human Services Louis W. Sullivan, MD, was a "blue-ribbon" panel of leaders in health, business, higher education, law, and other fields. The commission held regional public hearings, commissioned studies, and compiled a landmark report in 2004. Their report, *Missing Persons: Minorities in the Health Professions*, made policy recommendations to bring about systemic change that would address the scarcity of minorities in the health professions. The Sullivan Commission identified 3 major principles that are essential to achieving greater diversity: (1) the culture of health-professions schools must change in response to changing demographics; (2) new and nontraditional paths to the health professions should be explored; (3) and commitments to diversity must be at the highest levels. Expanding on the third principle, the report stressed the need for accountability and stated that "increasing diversity and cultural competency requires leadership, vision, political will, and a clear institutional mandate."²³

ACHIEVING WORKFORCE DIVERSITY: BARRIERS AND OPPORTUNITIES

These reports, as well as many other policy statements, have several features in common that have informed the development of this AAP policy statement. First is the need to pursue active recruitment of minority candidates for health-professions–education programs. To increase the small number of minority individuals entering pediatrics without a negative effect on the number entering other specialties, we must first increase the numbers of minority individuals entering medical school. Social, educational, financial, and other barriers act as disincentives to minority students who might otherwise be interested in careers in the health professions. As the Sullivan Commission observed:

“Even talented minority students who do succeed at primary, secondary, and collegiate levels, and who are committed to pursuing a career in one of the health professions, often find it difficult to gain admission to a health professions school. The barriers they encounter include an over-reliance on standardized testing in the admissions process, unsupportive institutional cultures, insufficient funding sources, and leadership without a demonstrated commitment to diversity.”²³

Another approach to increasing the recruitment of minority students into the health professions is to focus on reaching out to individuals in earlier educational stages, such as elementary school and high school. To maximize the effectiveness of these programs, appropriate support structures for these individuals within their communities, schools, postsecondary institutions, health care organizations, medical societies, and other entities need to be established. These support structures include financial incentives, mentoring and shadowing programs, adequate staffing for diversity programs, and educational and other initiatives related to cultural effectiveness and diversity.

A focus of many reports has been the expansion of financial incentives to encourage underrepresented minority students to enter medical training. These incentives, including loan forgiveness/repayment and tuition reimbursement, will help to address many of the financial barriers such as low family income and educational debt. These reports also articulate the importance of minority faculty serving as mentors to minority students, serving on admissions committees, overseeing diversity initiatives, and serving in leadership positions at all levels. To support all of these activities, there must be a commitment to increasing diversity at the highest organizational and institutional levels.

Finally, sponsors of diversity initiatives must likewise be able to track their progress in reaching specific targets and goals through research and data-driven outcome measures. It is difficult to improve what we cannot measure. Limited data on cultural minorities in medicine hamper the ability of the profession to evaluate the

current status of diversity, implement activities to enhance it, and measure the outcomes of these activities. More research on and better tracking of attributes other than race and ethnicity must be conducted to measure progress in improving diversity within medicine and pediatrics.

CONCLUSIONS

The medical community has made very little progress in diversifying its workforce, a fact that serves as the impetus for this policy statement’s focused recommendations on process, programmatic, and outcomes issues. Indeed, improving diversity within the pediatrician workforce will require proactive leadership from the medical community in a number of areas, including include recruitment, mentoring, education, organizational support systems, and financial incentives. Success will also depend on the collaboration and cooperation of stakeholders, including the AAP, on initiatives designed to promote diversity within the health professions.

RECOMMENDATIONS

The AAP is committed to working in collaboration with federal bodies, policy makers, medical and specialty societies, national minority organizations, AAP chapters, and other groups to achieve greater diversity in medicine, the health professions, and especially the pediatrician workforce and to implement the goals articulated in this policy statement. The following recommendations serve as guiding principles in this endeavor.

1. Affirmative-action programs should be designed to promote the entry of racial and ethnic minority students into medical school and, ultimately, into pediatrics.
2. Recruitment activities should support and advocate for the full spectrum of racial, ethnic, and cultural diversity, including language, national origin, religion, sexual orientation, physical disability, and other attributes, within the medical profession. These activities should maintain the high quality of the health care workforce and encourage individuals from all backgrounds to enter careers in pediatrics.
3. Recruitment and academic preparation of underrepresented minority students should begin in elementary school and continue through the entire scope of their education and professional formation. Efforts to recruit minority students into medical school and pediatrics should be targeted appropriately to each educational level.
4. Financial incentives should be increased to minority students, including federal funding for diversity programs, Title VII funding, loan-forgiveness/repayment programs, and tuition reimbursement.
5. Enhancing diversity within the pediatrician workforce will require a commitment at the highest levels. To put this commitment into practice, educational

and health care institutions, medical organizations, and other relevant bodies should hire staff who are responsible solely for the implementation, management, and evaluation of diversity programs and who are accountable to the organizational leadership. These programs should be integrated into the organization's operations and provided with an infrastructure adequate to implement and measure the effectiveness of their activities.

6. Institutional commitments to improve workforce diversity must include a formal program or mechanism to ensure that racial, ethnic, and cultural minority individuals rise to leadership positions at all levels. Approaches to increasing the diversity of the workforce in areas such as religion or sexual orientation are likely to require different approaches than those suggested for race.
7. Organizations with a stake in enhancing workforce diversity should implement systems to track data and information on race, ethnicity, and other cultural attributes.

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