Tuesday Nov 22, 2016

Doing My Part to Help Physician Workforce Reflect Diverse Population

As I watch the news or scroll through my Facebook feed, I see all that is happening in the world today and feel sad, angry and overwhelmed. I know, too, that this year's ill-fated events in Tulsa, Okla.; Charlotte, N.C.; Baton Rouge, La.; Dallas; Falcon Heights, Minn.; Orlando and many other cities have affected my patients -- even though we are separated from all of those violent acts by more than 1,000 miles.

Media accounts of these events have typically focused on race and injustice. I do not need to turn on my TV or check my smartphone to see what is going on with black lives. I see the impacts of racism, stereotypes, discrimination and social injustices every day -- sometimes all too close to home. And as a family physician, I see these factors play a role in the health disparities and inequities in our country.

Health inequities can be defined as health differences adversely affecting socially disadvantaged groups. Research has shown that when minority populations experience discrimination and racism, it can negatively impact their physical and mental health (https://www.ncbi.nlm.nih.gov/pubmed/8882842). Such experiences have also been shown to influence the likelihood that members of these populations will turn to harmful coping mechanisms such as tobacco, drugs and unhealthy foods to deal with stress. Minorities also are disproportionately affected by chronic diseases such as heart disease and diabetes. Many minority groups have less access to care, lack insurance coverage and receive poorer quality of care compared with nonminority populations.

Blacks represent nearly 13 percent of the U.S. population but less than 4 percent of the physician workforce.

I take care of various disadvantaged populations. I diagnose and treat illnesses, but there are things patients are born with that I cannot change, and, unfortunately, people often are judged by the color of their skin, the languages they speak and the country where they were born.

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I may not be exactly #whatadoctorlookslike in the eyes of many people (http://www.huffingtonpost.com/entry/black-women-are-speaking-out-to-show-the-world-whatadoctorlookslike_us_5801004ae4b06e047594630e), whether or not they're aware of holding that view. Most minority patients who see me for the first time are surprised when I walk into the room. "Are you the doctor?" they ask. After I say yes, they smile and say something like, "Wow, a young, black female doctor? That is great."

This exchange is usually followed by them asking how old I am and saying that I remind them of one of their relatives. This helps me build great rapport with my patients. I seem familiar to them, and this fosters trust (http://www.aafp.org/news/inside-aafp/20100803ntlconf-rodgers.html).

Sadly, this familiarity is lacking in many U.S. health care settings. Although blacks, Hispanics and Native Americans represented 12.8 percent, 11.3 percent and 0.9 percent of the population, respectively, in the 2000 census, those same groups represented only 3.3 percent, 2.8 percent and 0.3 percent of the physician workforce in 2004 (https://www.aamc.org/download/87306/data/physiciandiversityfacts.pdf). According to the Association of American Medical Colleges (AAMC), there actually has been a decline in the number of black men in medicine (https://news.aamc.org/diversity/article/decline-black-males-medicine/). One factor the AAMC cited for this trend is the negative public perception of black men -- a perception that may have worsened in light of the recent shootings and media coverage.

I have a passion to actively recruit and mentor minority students and residents. I think it is important to get more underrepresented minorities into the field of medicine. Research has demonstrated that minority doctors serve the majority of minority and underserved neighborhoods (http://archinte.jamanetwork.com/article.aspx?articleid=1792913). Thus, building a physician workforce that is more representative of the U.S. population could help address inequities in health and health care.

When minority physicians treat patients of the same minority group, it can lead to increased patient satisfaction and delivery of more culturally proficient care. Strong mentorship is key to encouraging interest in a career in medicine, and minority youth need role models to offer hope and guidance (http://www.aafp.org/medical-school-residency/faculty/pre-med/back-to-school.html).

Writing this blog is one way for me to say, "I am listening, I am here to help, and I understand." So what is my perspective? Black lives matter to me; all lives matter to me. That is why I became a doctor -- to help people. One of the reasons I specifically chose family medicine was so I could help a wide variety of people from birth to death. I chose to work in an urban population so I can help people who need it and who have limited access to that help.

It is important to me to inhabit a working environment that aligns with my mission, which is to improve access to high-quality, patient-centered primary health care targeted to the needs of medically underserved communities. As doctors, we wish we could fix all of the social and political injustices we see. When we sit down with our patients in the exam room, we can certainly make a difference there, whether it is just to acknowledge that racism exists and that it affects their health, or whether it is to listen to their stories, advocate for them and -- most importantly -- give excellent care to those who need it the most.

Joyce Robert, M.D.,C.L.C., is an associate medical director at a federally qualified health center/teaching health center in Harlem, N.Y. Her interests include minority health, lactation health and diversity in medicine.

Posted at 12:44PM Nov 22, 2016 (http://blogs.aafp.org/cfr/freshperspectives/entry/doing_my_part_to_help) by Joyce Robert, M.D. | Comments[2] (http://blogs.aafp.org/cfr/freshperspectives/entry/doing_my_part_to_help#comments)

Comments:

Joyce Robert, M.D. correctly points out that the representation in the physician workforce does not adequately represent African-Americans, Native Americans, and Hispanic Americans. In the article “AAMC Report Shows Decline of Black Males in Medicine” by Alicia Gallegos, special to AAMCNews, Dr. Roberts cites the statement “One factor the AAMC cited for this trend is the negative public perception of black men.” The suggestion she proposes that this is a perception that may have worsened in light of the recent shootings and media coverage is not cited in the article. This does not tell the whole story as discussed by the article she cites and does not help to foster a more substantive and meaningful discussion about why we don’t have more appropriate representation in the medical profession.
The larger discussion in the article, and in my view the most important, is the lack of role models and an

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educational environment which does not prepare these students to be competitive applicants. In the AAMC report according to Brian Smedley, PhD, co-founder and executive director of the National Collaborative for Health Equity, “Kids of color are more likely to be in low-performing schools that are under resourced.”
My position is that active recruiting and programs to promote “diversity” will fall short of expectations, and indeed foster false hope, unless we can address the disparity in educational opportunities which face many students especially in minority communities.

Posted by **Bradfor Williams M.D.** on November 22, 2016 at 06:24 PM CST #
(http://blogs.aafp.org/cfr/freshperspectives/entry/doing_my_part_to_help#comment-1479860648697)

I spent many years generating ratios of admission and trying to figure out how to start up the pipeline to rural practice with rural origin students. Such efforts have long been doomed to failure. There is simply too little health spending in rural locations to allow more to be supported.

The following are data and calculations that indicate that admission ratios are fixed in place by people factors. Certain environments, situations, behaviors, social determinants, and other local factors shape those most and least likely to gain admission just as they shape those most and least likely to have certain health outcomes. The individuals cannot be predicted but the probabilities can be generated.

The AMA Masterfile has birth origins and rural origin students were once 25% of the 1940s US medical students. These were also predominantly male. There is a steady decline to the level of 2 to 3% rural origin males in more recent class years. Study and reflection indicates the reasons for this decline.

Rural/lower population density
Lower to middle income
Not as likely to have professional parents
Lower property value school district in a nation that funds education based on property values
Not a prep high school
Not a top 147 college

Before birth to medical school admission factors are important. Exclusion of some just makes the others more important. Proper studies may well make it difficult to demonstrate race/ethnicity as a factor.

One out of ___ for this category listed became is a physician for 7 years of medical students (AAMC) and 7 years of medical school age census data for 2000.

Multiple Times Greater
17 Male Asian Indian – one of 17
24 Female Asian Indian
46 Male Chinese
48 Male All Asian Students
56 Female Top Quintile Income (60 - 65%)
61 Male Vietnamese
63 Female Chinese
66 Male Top Quintile Income (60 - 65%)
66 Female All Asian Students
98 Female Vietnamese

Close to Average Admission
166 Male All Urban Born
187 Male US All Student Total
192 Male White
193 Female 2nd Quintile Income (18 - 22%)
194 Female All Urban Born
209 Male 2nd Quintile Income (18 - 22%)
220 Female US All Student Total

Below Average Admission
267 Male All Foreign Born
290 Female White
298 Female All Foreign Born
302 Female All Rural Born
316 Male Only Native American

343 Female 3rd Quintile Income (9 - 13%)
348 Female Only Native American
364 Female Black

Behind in Admission
403 Male 3rd Quintile Income (9 - 13%)
433 Male All Rural Born
473 Male Any Native American
533 Female 4th Quintile Income (6 - 8%)
534 Male Black
534 Female Any Native American
572 Female Low Income Rural
706 Male 4th Quintile Income (6 - 8%)
737 Male All Hispanic
823 Male Low Income Rural
876 Female All Hispanic
892 Male Mexican American
999 Female Mexican American
999 Female Bottom Quintile Income (1 - 3%)
999 Male Bottom Quintile Income (1 - 3%)

County origin studies also reveal about 3 times greater with origins from most concentrated counties and 5 times less for those lowest in social determinants. Birth in a county with a medical school is a 1.5 times boost although if you reflect upon this, many babies were born during residency training – a reason for higher ratios where GME is most concentrated.

In general those at the top are moving up assuring that physicians are even less like the lower to lowest concentration Americans that are 40 – 50% of the population. Not surprisingly those that shape training, health policies, associations, and media have little concept of what most Americans are really like.

These studies do not include foreign born Americans that generally have a 2 to 1 advantage in admission (8 - 10% of the US pop and 16 - 20% of those admitted) or the 25% of US physicians who are foreign born from international medical schools (50% Asian). By all indications these are physicians that also share few of the characteristics of most Americans and also live in the most concentrated settings before, during, and after residency training.

Only 6.5% of residency training is found in the 2621 lowest physician concentration counties where 40% of the population is found – one of the greatest spending disparities discovered so far. Designs for health and education also shape disparities by impacting services, access, education, organization, jobs, economics, cash flow, and more.

Choice of family medicine also varies. At the time the range was 2% to 7% for those most likely to be admitted to 14% for the average to 18 – 25% for those least likely to gain admission.
Highest concentration county origins have 2 to 3 times admission levels or 14 to 21 per 100,000 in the birth county category with 1 family doc arising from these at 5 – 7%.
The average was about 7 – 9 admitted per 100,000 in the birth county category with 1 per 100,000 found in FM for about 11 – 14%.
Lowest concentration counties have only 4 per 100,000 with 1 found in FM for 25% FM.

Many factors shape choice of FM, but demographics should not be ignored. Also few experience FM in the top concentration counties where so many other physicians are found (FM is 30 per 100,000 compared to 400 docs per 100,000). However in lowest concentration settings FM is 26 per 100,000 or 23% of the 115 docs per 100,000. Situations, behaviors, environments, determinants, and other people factors shape many areas of health outcomes.

If we do not learn to try to reshape the people factors – we will add more and more to costs without improvements in outcomes – whether spending the dollars on pipelines, or medical error focus, or managed high risk or managed high cost or quality metrics, etc.

One huge advantage of FM is seen in small practices that help prevent preventable admissions. FM and those in small practices can make a difference in people factors while others are mainly adding to the costs and consequences.

Posted by **Robert C. Bowman, M.D.** (http://www.basichealthaccess.blogspot.com) on November 23, 2016 at 12:33 AM

CST # (http://blogs.aafp.org/cfr/freshperspectives/entry/doing_my_part_to_help#comment-1479882827487)

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