

**Testimony to the Sullivan Commission on Diversity in the Healthcare Workforce  
October 20, 2003, Chicago, IL  
from the  
American Medical Association  
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On behalf of the American Medical Association (AMA), I am pleased with the opportunity to submit comments to the Sullivan Commission on this critical issue. The AMA commends our esteemed colleague, Dr. Louis Sullivan, for convening and challenging this Commission to develop recommendations on increasing the number of underrepresented minorities in health care and closing the nation's health gap.

The AMA is also committed to the achievement of that goal. Since first founded more than 150 years ago, the AMA has worked to uphold the highest ethical standards for medicine and health care and to strengthen physician professionalism through medical education and accreditation, research, and policy. Most importantly, as it says on our letterhead, we are "physicians dedicated to the health of America."

This means the health of ALL Americans. The existence of racial and ethnic health disparities cannot be tolerated. The AMA is committed to the elimination of such disparities and to creating a workforce of health professionals that reflects and can address the diversity of our patients.

The profession must view racial and ethnic health disparities through the lens of quality. Improving quality through the components of patient safety, timely response, and evidence-based, patient-centered care provides a framework for eliminating disparities. Meeting the needs of the patient population should be the focus of our efforts. Physicians have a professional and moral obligation to deliver the best possible quality of care to everyone.

Earlier this month, AMA convened a task force on health care disparities which included representatives from active state and medical specialty societies, the National Medical Association and National Hispanic Medical Association, and the federal government. Key to that discussion was the thread of increasing diversity in medical education and practice. The group's consensus was clear; we must act to now to increase workforce diversity.

### **Racial and Ethnic Health Disparities**

Despite steady improvements in the overall health of Americans, significant racial and ethnic disparities in health status remain. African Americans experience higher rates of morbidity and mortality from a number of diseases, including heart disease and stroke, cancer, diabetes, asthma, HIV/AIDS, and cerebrovascular disease. Similarly, Hispanic Americans experience disproportionate rates of morbidity and mortality from diabetes, cancer, and heart disease. American Indian and Alaska Natives are disadvantaged on a number of health status indicators, including life expectancy and infant mortality. Finally, some Asian American subpopulations experience rates of certain cancers that are well above national averages.

The reasons for these disparities are complex. Socioeconomic inequality, individual behavioral risk factors, and cultural factors are all correlated with health status. Disparities in access to health care also clearly play a role. Of most concern, evidence suggests that racial and ethnic

minorities receive lower quality and quantity of health services compared to white Americans even at equivalent levels of access to care. This was most recently documented in the IOM report, “Unequal Treatment, Confronting Racial and Ethnic Health Disparities.”

Minority race and/or ethnicity has been linked to a lower likelihood of having a regular source of care, fewer physician visits, less-intensive hospital visits, and lower total health care expenditures. Minority race and ethnicity are also risk factors for less care across a range of health care services, including receipt of appropriate cancer diagnostic tests and treatment; screening, diagnostic and therapeutic interventions for heart disease and stroke; asthma, diabetes and HIV care; renal transplantation; and a range of other preventive and specialty health services. While most studies have examined disparities in health care only among adult populations, racial and ethnic minority children and adolescents are also at considerable health disadvantage.

### **Diversity in the Medical Profession**

Increasing the number of underrepresented minority physicians and medical students is an important strategy in the elimination of racial and ethnic care disparities and the improvement of US health status.

By 2050, 50% of the US population will be minorities. However, the number of underrepresented minority medical students continues to bear an inverse relationship to the rising numbers of minorities in the U.S. population. Only 7% of practicing physicians in the U.S. are from underrepresented minority group while 25% of the patient population is from these same racial and ethnic minority groups. The underrepresented minority applicant pool and acceptance rates in U.S. medical schools have declined steadily since 1996 (Association of American Medical Colleges (AAMC), 2003).

The need for more minority physicians is clear. Evidence exists that minority patients are more satisfied with their care from minority physicians than that received from non-minority physicians. Minority physicians are more likely to return to their communities. The 2001 AAMC study of medical graduates found that two-thirds of underrepresented minority medical school graduates planed to specialize in primary care and practice in underserved areas compared to one-third of non-underrepresented minorities. The issue of trust in the physician patient relationship must be recognized. Studies have shown that higher levels of trust between patients and their physicians are correlated with positive health outcomes. Yet trust is often compromised across racial and ethnic lines. Finally, we know that health outcomes are often enhanced through better understanding of and exposure to cultural, ethnic, language and other factors.

However, the US has made very little progress in increasing racial and ethnic diversity in medical education and practice. This lack of progress is not acceptable. The task before all of us mandates a compelling and immediate need for each of our organizations to undertake much more than any of us can do alone. A collective commitment and a collection of actions according to our strengths and constituencies is needed to forge lasting solutions.

### **Recommendations**

#### Essential Elements

##### **I. Building pipelines.**

There is general agreement that a major element in increasing diversity in the health professions and medical schools is the continued need to build a pipeline of future physicians, nurses, dentist and allied health professionals among children of color. These

motivational and educational goals must be implemented at the elementary education level and sustained throughout the educational system. Local and national enrichment programs must be developed to provide additional and supplemental education to students of potential.

II. Identifying, developing and replicating the elements of successful admission policies/practices.

The profession should identify and explore the disparities in applications and acceptance rates, in order to create models for future success in recruiting and retaining minorities in medicine. As with previous IOM reports, a thorough accumulation and review of data and historical trends can contribute significantly to the building of a national consensus and call to action. Academic institutions should be encouraged to incorporate in their mission statements the benefits of admitting students on the basis of serving diverse patient populations.

III. Developing curricula, training methods and measurements for enhancing cross-cultural skills and competencies for medical students and physicians.

Educational curriculum and training requirements should specifically address the cultural effectiveness needed by all physicians practicing in the US, today and in the future. This should include rotations in underserved communities or populations and other community outreach initiatives. Students' success in the acquisition of cross-cultural communication skills should be measured. Curriculum should specifically address the reasons for ethnic and racial disparities in health outcomes. Our future physicians must be prepared to meet the needs of our increasingly diverse society. Continuing medical education for practicing physicians must also incorporate these goals.

IV. Reducing financial barriers for minority students.

An important factor preventing some qualified minorities from pursuing medicine as a career is the high cost of college and medical school. With the average medical student debt at over \$103,000, the financing of medical education and training is a significant concern for most medical students. However, minority students often bear a higher burden of cost and a higher debt load. A 1995 report from the AAMC noted substantial differences in the median family incomes of students from various racial and ethnic groups. Exploring the development of new or enhanced scholarship and loan forgiveness programs would help to address these financial barriers and, at the same time, increase opportunities to bring needed health care to underserved communities. In addition, the ability of minority students to access existing financial aid programs should be examined for unintended barriers that may have the effect of diminishing opportunities for minorities in the health professions.

V. Diversifying the institutional environment and increasing minority faculty.

Along with the under representation of minorities in medical school enrollment, there are also disparities in minority representation among medical school faculty and residency training directors. Minority mentorship programs, as well as other traditional and non traditional support programs, should be explored for their potential in elevating more minorities into visible and influential decision-making positions. Specific policies and programs that are working to attract a diverse workforce and student applicant pool should be rewarded with recognition and financial support.

VI. Collecting data by race and ethnicity.

The collection of data by race and ethnicity must be encouraged in order to identify disparities and emerging trends, monitor progress in increasing diversity, eliminate racial and ethnic health disparities, and building an evidence-based case cultural competency. The recent defeat of Proposition 54 in California was a welcome outcome, but the issue is sure to be raised again in the future.

### The Role of Professional Associations

Organized medicine can and should have a powerful role in nurturing a future generation of male and female physicians who are racially and ethnically diverse and who can deliver culturally appropriate and culturally effective health care. Our professional organizations must tap into our strengths – grassroots outreach, political power, professional standards – and intensify our commitment and ability to sustain a united effort.

#### I. LEADERSHIP. Professional associations must work to:

- A. Achieve commitment and stakeholder support throughout the federation of medicine. It is important for all professional organizations to commit resources and share information and perspectives in order to create and sustain a successful effort to increase diversity. The AMA will continue to use our convener role to build consensus and develop implementation strategies.
- B. Raise awareness and provide education for grassroots physicians on eliminating minority disparities in their practice environments. This should be integrated into scientific and health policy and continuing medical education programming.
- C. Lead by example including developing and training new leaders among minority physicians, encouraging a diversity of voices in policy debates, building a diverse staff, and incorporating diversity in their organization imaging and publishing.
- D. Partner with academic institutions to develop curricula and training that will enhance cultural understanding and to promote career development incentives for health care professionals in grassroots role-modeling and mentoring programs that target underrepresented minority students.
- E. Promote local community partnerships and initiatives. Professional organizations must encourage their members to participate in community activities that will help to promote and attract a diverse workforce and pique interest among underrepresented minority students in careers in medicine and other health professions. Broad based national programs should be considered as well as local initiatives. Examples of such programs include the *AMA Doctors Back to School Program* in which minority physicians are encouraged to visit their local schools as role models and to offer academic encouragement to children of color. Other efforts include adopt a school programs, health education preceptor community outreach efforts, and local mentoring programs.
- F. Promote the AMA Principles for Medical Ethics which emphasize the professional obligations of physicians toward the betterment of public health, quality care, and access to medical care for all populations.

#### II. ADVOCACY AND PROFESSIONAL STANDARDS. Professional organizations must:

- A. Develop and promote health policies that provide guidelines and standards on clinical and practice issues effecting minority health care and promotes culturally appropriate care.
- B. Participate in advocacy efforts in Congress and at the local level regarding innovative legislative approaches to addressing minority health issues.
- C. Support continued federal funding for diversity programs. The National Institutes of Health, Department of Health and Human Services, Agency for Health Care Quality and Research should be assured of adequate funding and federal leadership in continuing their current programs.
- D. Work to remove financial barriers for minorities who pursue careers in healthcare. Organizations should support the development of loan forgiveness programs and scholarships specifically targeted to attracting minority students.
- E. Advocate for the continued support of the Historically Black and Hispanic-Serving Medical Colleges. With declining medical school applications and increasing competition for minority enrollment among professional institutions, the need remains for strong Historically Black and Hispanic Serving Medical Colleges. We must make our voices heard on this issue.
- F. Work toward a cultural shift in the profession that promotes the value of a more diverse health care workforce, quantifies the professional/ business case for incorporating cultural competence in health care practices, and fosters commitment to the elimination of racial and ethnic health disparities.

Thank you for the opportunity to share the views of the AMA with the Sullivan Commission. The AMA remains committed to participating in professional partnerships aimed at eliminating racial and ethnic health disparities and increasing diversity throughout the health professions.