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Commentary

A diverse nation calls for a diverse healthcare force

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By 2060, more than 50% of Americans will identify as a race other than white[1]. Yet less than 12% of physicians in 2018 were underrepresented in medicine (UIM) [2]. These numbers are even more striking within healthcare leadership, with 98% of healthcare organization leaders being White [3]. Racial and ethnic minorities are underrepresented in other sectors of medicine making up roughly 19.2% and 8% of registered nurses and PhD investigators, respectively [4,5]. These statistics emphasize the need to urgently and systematically address homogeneity in the medical workforce, which has been documented to negatively impact health outcomes, particularly amongst those from underserved backgrounds as well as racial and ethnic minorities [6–8]. Inclusive leadership and diverse, interprofessional healthcare teams have proven fundamental for bridging cultural divides, strengthing collaboarations, and ultimately providing comprehensive care to underserved populations by reducing health disparities, healthcare costs, and inefficient use of the healthcare system [6–8]. This paper provides a roadmap on how to increase diversity within multiple sectors of the healthcare industry in order to make it more reflective of this nation's racial and ethnic demographic make-up.

Structural and institutional change begins with a top-down approach, starting with senior leaders and governing bodies. Senior leaders include organizational and health policy leaders, hospital chief executive officers (CEOs), journal editorial boards, principal investigators, residency program directors, department chairs, and faculty at the schools of medicine, dentistry, nursing, pharmacy, and social work. Governing organizations in healthcare include but are not limited to, the American Medical Association (AMA), the National Medical Association (NMA), National Hispanic Medical Association (NHMA), Accreditation Councle for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), the United States Medical Licensing Exam (USMLE), the National Institute of Health (NIH), National Dental Association (NDA), American Nurses Association (ANA), American Pharmacists Associaiton (APA) and National Association of Social Workers (NASW). Recruitment, tenure, and promotion of racial and ethnic minorities to senior positions in the healthcare workforce as well as cultural competency training of current leaders is important to address the needs of medically marginalized populations. UIMs in leadership positions can provide unique perspectives that will help advance inclusive policies that increase patient access, facilitate the recruitment and promotion of diverse leaders and faculty, and increase representation in research. Finally, these bodies must work together to establish healthcare teams who prioritize reducing healthcare disparities and serve as champions for diversity in medicine.

Leaders, particularly hospital CEOs and program directors, should establish cultural competency and interprofessional training to help hospital staff and medical professionals collaborate with other sectors of the medical industry. Considering fragmented, uncoordinated health services create another barrier to cultural competency [3], team-based care amongst clinicans, nurses, social workers, and other professionals with significant patient interaction is imperative. It is well documented that both racially and ethnically diverse and multidisciplinary healthcare teams allows for more informed, patient-centered decision making as well as reduced barriers to care and patient advocacy [3].

With respect to research, mentoring programs and dedicated funding will help UIM clinicians and PhD investigators navigate the research and clinical trial space and will support studies focusing on health conditions disproportionately affecting racial and ethnic minorities. Additionally, medical journals must diversify their editorial boards, while ensuring their published articles include diversity in authorship and content including discussion of diseases disproportionately affecting medically marginalized populations.

Targeting medical education is another important step to creating a diverse and inclusive workforce. UIM faculty are more likely to mentor UIM students, serve on diversity committees, and work with underserved populations [9]. The time commitment to these activities may negatively impact their career advancement. UIM faculty often work with fewer resources and more socially complex, underserved patients, resulting in greater clinical burden and burnout, and thus, less protected time for research or involvement in other areas

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of healthcare including advocacy and policy [1,6,9,10]. With increasing numbers of UIMs in medicine, institutional recognition and support of this work, particularly when considering faculty for promotion, is imperative for the retention of UIM faculty. Additional efforts may include protected time and/or compensation for faculty members who mentor UIM students, devote time to pipeline programs, and engage in community outreach [1]. Many academic faculty spend 20% of their time or less on advocacy work, due to its lack of recognition and department and/or institutional support [10]. Institutional support will likely encourage more UIM faculty to participate in research, authorship, and advocacy, particularly in relation to public health policy. Such efforts may also serve as an incentive to engage more non-UIM faculty in these activities.

At the medical student level, increasing representation requires leaders of diversity, equity, and inclusion serving on admission committees [1]. Additionally, prerequisite courses for medical school and medical school coursework should include topics which cover health care disparities, racism in medicine, implicit bias, and cultural competency. Including these topics in standardized examinations, including the MCAT and USMLE board exams may also help to underscore their significance [7]. Funding to address educational inequalities in grades K-12, decrease the economic burden for UIM applicants, and support UIM trainees will reduce additional barriers [1,6]. Finally, to ensure success, institutions may consider monitoring the outcomes of these programs. Similar efforts should be made within other sectors of medical education and training, including schools of nursing, dentistry, pharmacy, social work, and public health.

In 2021, we are neither where we hoped or need to be with regards to diverse and inclusive representation in medicine. Our work today determines the quality of patient care for the future and the ability to close the gap in healthcare disparities. With the continued diversification of this nation, ensuring diversity in medicine serves as a testament to our commitment to care for our most vulnerable and raises the standard of excellence to provide health equity for all.

Declarations of Interests

Dr. Nada Elbuluk is the Director of the Diversity and Inclusion Program in the Department of Dermatology at Keck of USC. Dr. Susan Taylor is the Vice Chair for Diversity, Equity, and Inclusion in the Department of Dermatology at Perelman School of Medicine. The other authors have nothing to disclose.

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