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# Understanding and Addressing Disparities and Discrimination in Education and in the Physician Workforce

A Position Paper of the  
American College of Physicians

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## Abstract

Racial and ethnic minority populations in the U.S. experience disparities in their health and health care that arise from a combination of interacting factors, including racism and discrimination, social drivers of health, health care access and quality, individual behavior, and biology. To ameliorate these disparities, the American College of Physicians (ACP) proposes a comprehensive policy framework that recognizes and confronts the many elements of U.S. society, some of which are intertwined and compounding, that contribute to poorer health outcomes. Ensuring a diverse health care workforce that is representative of the patients it serves is crucial in building trust and understanding between patients and health care professionals of different backgrounds. However, to enhance the physician pathway and also equip patients with the knowledge and skills necessary for living healthy lives, barriers and inequities in education at all levels must be eliminated. To achieve these goals, this ACP position paper makes recommendations for safe, inclusive, and supportive educational and workplace environments; diverse medical school bodies and workforces; and supporting, funding, and strengthening education at all levels.

## Introduction

In this position paper, the American College of Physicians (ACP) proposes recommendations for addressing disparities and discrimination based on race, ethnicity, religion, and cultural characteristics and identities in the context of education and the physician workforce. These recommendations are made as part of ACP's comprehensive, interconnected, and evidence-based policy framework to address racial and ethnic health disparities. This framework, which is outlined in an accompanying proposal (1), includes 17 recommendations, four of which are expanded upon and discussed in more detail in this paper. The two other companion papers address specific issues affecting the health and health care of those populations most at risk (2) as well as discrimination and disparities in criminal justice and law enforcement and their impact on health (3). Together, these four papers provide a comprehensive and interconnected policy approach to addressing important issues cutting across clinics, hospitals, schools, universities, prisons, and various other elements of society to achieve ACP's holistic vision to eliminating health disparities.

Disparities exist in all levels of education. At the primary and secondary education levels, disparities in resources can impact quality, opportunities, and outcomes, particularly for persons most affected because of their race, ethnicity, and cultural characteristics and identities. Education is an important social determinant of health as it can determine access to safer neighborhoods, financial resources, employment opportunities (and in turn insurance coverage), and the skills and reasoning necessary for producing health (4,5). More education has been associated with longer life expectancy (6,7), lower mortality rates (8), and lower rates of risk factors (7). The effect of these primary and secondary education disparities can appear in medical school, where only 6.2% of students are Black, 5.3% Hispanic or Latino, 0.2% American Indian or Alaska Native, and 0.1% Native Hawaiian or Pacific Islander (9).

These disparities can further in part translate to disparities in the physician workforce: 5.8% of physicians are Hispanic, 5% Black, 0.3% American Indian or Alaska Native, and 0.1% Native Hawaiian or Pacific Islander (10). Physicians from underrepresented backgrounds can face numerous barriers, discrimination (11,12), a lack of career advancement and mentors (13), and the burden of extra responsibilities for diversity activities and services (14,15). Several studies have found that racial and ethnic minority patients with racially concordant physicians have experienced improvements in outcomes (16) and rates of preventive services (17), which demonstrates the importance of recruitment and retention of physicians of underrepresented backgrounds. In addition, physicians from underrepresented backgrounds are more likely to see racial and ethnic



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## Background and Rationale

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**current discriminatory practices and the legacy of past discrimination practices and better reflect the current composition of the population. Programs that provide outreach to encourage racial and ethnic minority enrollment in medical and other health professional schools should be maintained, reinstated, and expanded, including diversity/minority affairs offices, scholarships, and other financial aid programs.**

- d. All arenas of the health care workforce should be incentivized to implement evidence-based best practices**

projections, there is a clear gap between the ratio of Black or African American, Hispanic or Latino, and American Indian or Alaska Native physicians to their respective racial/ethnic group's population percentage. These gaps identify Black or African American, Hispanic or Latino, and American Indian or Alaska Native physicians as underrepresented minorities (URM) in the U.S. health care workforce. U.S. Census population estimates from 2019 identify 76.5% of the population as being White, 18.3% as Hispanic or Latino, 13.4% as Black or African American, 5.9% as Asian American, 2.7% as two or more races, 1.3% as American Indian and Alaska Native, and 0.2% as Native Hawaiian and Pacific Islander (55).

A number of studies have shown URM physicians are more likely than White physicians to see patients in underserved communities, provide care to low-income patients and to those on Medicaid, and treat more racial and ethnic minority patients. Additionally, racial and ethnic minority patients report higher-quality care and higher care satisfaction when treated by a physician of the same racial or ethnic background. One study found that Black men who saw Black male doctors were more likely to opt for preventive screening tests, particularly those more invasive, and were more likely to discuss other health problems than those with White male doctors (17). Another study found that newborn-physician racial concordance was associated with improvements in mortality for Black newborns (16).

Increased diversity in the health care workforce not only benefits minority patients but improves care for all patients. Evidence has shown diverse populations in educational and medical training settings improves learning outcomes by increasing active thinking and intellectual engagement skills and increases understanding of and empathy for diverse cultures (56). Improving these learning outcomes is critical as a 2020 survey analysis showed third-year medical students reported moderate comfort while navigating complex clinical

students has increased over the years, their numbers have been relatively flat compared to the overall population growth for these communities. An analysis of medical school applicants and matriculants between 2002 and 2017 found that

widespread efforts are needed to root out forms of structural racism and foster environments to attract and support racial and ethnic minority medical students.

Racism and bias in medical schools must be addressed to create a learning environment welcoming and supportive of minority students. Racial and ethnic minority students are more likely to report adverse medical school experiences as a result of their race due to discrimination, prejudice, feelings of isolation, and different cultural experiences and these students were more likely to report burnout, depressive symptoms, and low mental quality of life (73). One study found 38% of URM medical students reported mistreatment while in school compared to only 24% of White students. Researchers noted the potential impact of racism in medical education on the low numbers of racial and ethnic minorities who enter and complete medical school. Discriminatory comments have lasting effects on the targets and bystanders who may feel uncomfortable or unwanted in medicine by certain comments (74). Additionally, some research suggests that medical school admissions committees display unconscious White preference (75), creating additional institutional barriers for Black, Indigenous, Latinx, Asian American, N result of their race due thg2ue thg0.5 (r) Hesult of theiwesult of theiif theiif t

improve diversity in faculty hiring. Practices like assembling diverse hiring committees, providing implicit bias workshops for hiring committees, drafting broad job descriptions that include cues of belonging, targeted outreach and advertisement of job postings, relationship building with targeted communities, and incorporation of diversity statements in the assessment process have been found to increase diversity in faculty hires (84,85,86,87). Hiring committees should avoid relying on flawed proxies for quality that may be subject to bias, such as where a candidate has trained or been published (84). Pathway programs can help identify, foster, and attract faculty candidates of diverse backgrounds to an institution (88). One such example is the Chicago Cancer Health Equity Collaborative Research Fellows Program, which provides exposure to local students through opportunities to network with health care professionals in the community, lab experiences, research rotations, professional sA bi-US

Educational attainment is often linked to health status and the role of education as a social determinant of health is established throughout the literature (91). An analysis of deaths in the U.S. between 2010 and 2017 found that average life expectancy increased for those with a college degree, whereas it decreased for those without (6). The life expectancy gap between the most and least educated has grown from 13 years for men and 8 years for women in 1990 to 14 years and 10 years in 2008, respectively, a trend that has widened since the 1960s (7). Overall mortality rates are roughly four times higher for those without a high school degree compared to those with more than 16 years of education (8). An analysis of patients with coronary artery disease found



poverty areas, which are 80% Black or Hispanic, offered less access to college-prep courses and fewer math and science courses expected by colleges (102). Fewer Black students were found to take advanced courses and dual-credit programs or have access to advanced tracked programs compared to White, and in some cases Asian American students (102). Hispanic, Black, and American Indian and Alaska Native students had lower high school graduation rates as

## Appendix: Glossary

**Black:** The term *Black* is used rather than *African American* to capture the shared and distinct experiences of both those who are descended from enslaved Africans brought to North America who have a long history in the United States as well as others who have more recently immigrated from African, Caribbean, and other countries and who may not as strongly identify with the American identity.

**Latinx:** Gender-neutral term to refer to those living in the United States who are of Latin American descent, rather than *Hispanic*, which refers to those who share Spanish as a common language. While respecting the views of those who do not prefer to be called Latinx, we conclude that *Latinx* captures power and privilege dynamics in the United States better than *Hispanic*, which would include those of Spanish descent who would identify as White but would exclude those of Brazilian descent and other non-Spanish-speaking Latin American countries. When referencing other sources, we use the descriptors the authors used. We recognize the controversy over the use of *Latinx*: Some argue that the term imposes American and Anglocentric ideals, encompasses a broad and diverse group, is incomprehensible to native Spanish speakers without any fluency in English—some of the very people the term is meant to serve—and is not a term that most persons of Latin American descent identify with. Although an imperfect solution, we choose to use the gender-neutral *Latinx* over Latino (in Spanish, many nouns and adjectives are gendered, with nouns ending in -o typically using masculine pronouns) in an effort to be as inclusive as possible.

**Social drivers of health:** n-Ue024 44 0 10 145 44orpan 2cm ( )JTJETSf-h9wng (enC BT/T1\_0 1s

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- 19 Devine PG, Forscher PS, Austin AJ, Cox WT. Long-term reduction in implicit race bias: A prejudice habit-breaking intervention. *J Exp Soc Psychol*. 2012 Nov;48(6):1267-1278. doi: 10.1016/j.jesp.2012.06.003. PMID: 23524616; PMCID: PMC3603687.
- 20 Greenwald AG, Poehlman TA, Uhlmann EL, Banaji MR. Understanding and using the Implicit Association Test: III. Meta-analysis of predictive validity. *J Pers Soc Psychol*. 2009 Jul;97(1):17-41. doi: 10.1037/a0015575. PMID: 19586237.
- 21 Discrimination in America: Experiences and Views [Internet]. RWJF. 2020 [cited 2020]. Available from: <https://www.rwjf.org/en/library/research/2017/10/discrimination-in-america--experiences-and-views.html>
- 22 Hall WJ, Chapman MV, Lee KM, Merino YM, Thomas TW, Payne BK, Eng E, Day SH, Coyne-Beasley T. Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. *Am J Public Health*. 2015 Dec;105(12):e60-76. doi: 10.2105/AJPH.2015.302903. Epub 2015 Oct 15. PMID: 26469668; PMCID: PMC4638275.
- 23 Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences*. 2016Apr4;113(16):4296-301.
- 24 Sabin JA, Greenwald AG. The Influence of Implicit Bias on Treatment Recommendations for 4 Common Pediatric Conditions: Pain, Urinary Tract Infection, Attention Deficit Hyperactivity Disorder, and Asthma. *American Journal of Public Health [Internet]*. 2012May [cited 2020];102(5):988-94. Available from: <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2011.300621>

- 38 Marcelin JR, Siraj DS, Victor R, Kotadia S, Maldonado YA. The Impact of Unconscious Bias in Healthcare: How to Recognize and Mitigate It. *The Journal of Infectious Diseases*. 2019Aug20;220(Supplement\_2).
- 39 Yeager KA, Bauer-Wu S. Cultural humility: essential foundation for clinical researchers. *Appl Nurs Res*. 2013 Nov;26(4):251-6. doi: 10.1016/j.apnr.2013.06.008. Epub 2013 Aug 12. PMID: 23938129; PMCID: PMC3834043.
- 40 Prasad SJ, Nair P, Gadhvi K, Barai I, Danish HS, Philip AB. Cultural humility: treating the patient, not the illness. *Med Educ Online*. 2016 Feb 3;21:30908. doi: 10.3402/meo.v21.30908. PMID: 26847853; PMCID: PMC4742464.
- 41 Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved*. 1998 May;9(2):117-25. doi: 10.1353/hpu.2010.0233. PMID: 10073197.
- 42 Greene-Moton E, Minkler M. Cultural Competence or Cultural Humility? Moving Beyond the Debate. *Health Promot Pract*. 2020 Jan;21(1):142-145. doi: 10.1177/1524839919884912. Epub 2019 Nov 12. PMID: 31718301.
- 43 Metz J, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. *Soc Sci Med*. 2014 Feb;103:126-133. doi: 10.1016/j.socscimed.2013.06.032. PMID: 24507917; PMCID: PMC4269606.
- 44 Downey MM, Gómez AM. *AMA J Ethics*. 2018;20(3):211-223. doi: 10.1001/journalofethics.2018.20.3.peer1-1803.
- 45 Nelson TD. The self-regulation of prejudice. In: *Handbook of Prejudice, Stereotyping, and Discrimination*. New York, NY: Routledge; 2009:507-523.
- 46 White-Davis T, Edgoose J, Speights JSB, Fraser K, Ring JM, Guh J, et al. Addressing Racism in Medical Education. *Family Medicine*. 2018May;50(5):364-8.
- 47 Teal CR, Shada RE, Gill AC, Thompson BM, Frugé E, Villarreal GB, et al. When Best Intentions Aren't Enough: Helping Medical Students Develop Strategies for Managing Bias about Patients. *Journal of General Internal Medicine*. 2010;25(S2):115-8.
- 48 Chapman EN, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. *J Gen Intern Med*. 2013 Nov;28(11):1504-10. doi: 10.1007/s11606-013-2441-1. Epub 2013 Apr 11. PMID: 23576243; PMCID: PMC3797360.
- 49 Burgess D, van Ryn M, Dovidio J, Saha S. Reducing racial bias among health care providers: lessons from social-cognitive psychology. *J Gen Intern Med*. 2007 Jun;22(6):882-7. doi: 10.1007/s11606-007-0160-1. Epub 2007 Mar 3. PMID: 17503111; PMCID: PMC2219858.
- 50 Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at [ihi.org](http://ihi.org))
- 51 Kalev A, Dobbin F, Kelly E. Best Practices or Best Guesses? Assessing the Efficacy of Corporate Affirmative Action and Diversity Policies. *American Sociological Review*. 2006Aug1;71(4):589-617.
- 52 Singal J. Psychology's Favorite Tool for Measuring Racism Isn't Up to the Job [Internet]. *The Cut*. 2017 [cited 2020]. Available from: <https://www.thecut.com/2017/01/psychologys-racism-measuring-tool-isnt-up-to-the-job.html>
- 53 Forscher, P. S., Lai, C. K., Axt, J. R., Ebersole, C. R., Herman, M., Devine, P. G., & Nosek, B. A. (2019). A meta-analysis of procedures to change implicit measures. *Journal of Personality and Social Psychology*, 117(3), 522-559. <https://doi.org/10.1037/a2cMassachusetts: Institute for v1rg9D DC BT9 0 0 9 112 222.4562>

- 59 Boatright DH, Samuels EA, Cramer L, et al. Association Between the Liaison Committee on Medical Education's Diversity Standards and Changes in Percentage of Medical Student Sex, Race, and Ethnicity. *JAMA*. 2018;320(21):2267-2269. doi:10.1001/jama.2018.1370.

60

- 82 Page KR, Castillo-Page L, Wright SM. Faculty diversity programs in U.S. medical schools and characteristics associated with higher faculty diversity. *Acad Med*. 2011 Oct;86(10):1221-8. doi: 10.1097/ACM.0b013e31822c066d. PMID: 21869663; PMCID: PMC3184185.
- 83 Hassouneh D, Lutz KF, Beckett AK, Junkins EP, Horton LL. The experiences of underrepresented minority faculty in schools of medicine. *Med Educ Online*. 2014 Dec 2;19:24768. doi: 10.3402/meo.v19.24768. PMID: 25472784; PMCID: PMC4255094.
- 84 Bhalla N. Strategies to improve equity in faculty hiring. *Mol Biol Cell*. 2019 Oct 15;30(22):2744-2749. doi: 10.1091/mbc.E19-08-0476. PMID: 31609672; PMCID: PMC6789160.
- 85 Smith JL, Handley IM, Zale AV, Rushing S, Potvin MA. Now Hiring! Empirically Testing a Three-Step Intervention to Increase Faculty Gender Diversity in STEM. *BioScience*. 2015Oct10;65(11):1084-7.
- 86 Guide to Best Practices in Faculty Search and Hiring [Internet]. Columbia University Office of the Provost. 2016 [cited 2020]. Available from: <https://provost.columbia.edu/sites/default/files/content/BestPracticesFacultySearchHiring.pdf>
- 87 Stewart AJ, Valian V. Recruiting Diverse and Excellent New Faculty. *Inside Higher Ed*. 2018.
- 88 Williams D, Wade-Golden KC. Best Practices for Improving Faculty Diversity Recruitment and Retention. In: *The chief diversity officer: strategy, structure, and change management*. Sterling, VA: Stylus; 2013.
- 89 Taylor SM. The Health Care Career Pipeline: A Program Director's Reflection on Extending the Resources of the University to the Minority Student Community [Internet]. National Academy of Medicine. 2018 [cited 2020]. Available from: <https://nam.edu/the-health-care-career-pipeline-a-program-directors-reflection-on-extending-the-resources-of-the-university-to-the-minority-student-community/>
- 90 Blackstock U. Why Black doctors like me are leaving academic medicine [Internet]. *STAT*. 2020 [cited 2020]. Available from: <https://www.statnews.com/2020/01/16/black-doctors-leaving-faculty-positions-academic-medical-centers/>
- 91 Hahn RA, Truman BI. Education Improves Public Health and Promotes Health Equity. *Int J Health Serv*. 2015;45(4):657-78. doi: 10.1177/0020731415585986. Epub 2015 May 19. PMID: 25995305; PMCID: PMC4691207.
- 92 Kelli HM, Mehta A, Tahhan AS, Liu C, Kim JH, Dong TA, et al. Low Educational Attainment is a Predictor of Adverse Outcomes in Patients With Coronary Artery Disease. *Journal of the American Heart Association*. 2019Sep2;8(17).
- 93 Dégano IR, Marrugat J, Grau M, Salvador-González B, Ramos R, Zamora A, Martí R, Elosua R. The association between education and cardiovascular disease incidence is mediated by hypertension, diabetes, and body mass index. *Sci Rep*. 2017 Sep 28;7(1):12370. doi: 10.1038/s41598-017-10775-3. PMID: 28959022; PMCID: PMC5620039.
- 94 Lee JR, Paultre F, Mosca L. The association between educational level and risk of cardiovascular disease fatality among women with cardiovascular disease. *Womens Health Issues*. 2005 Mar-Apr;15(2):80-8. doi: 10.1016/j.whi.2004.11.004. PMID: 15767198.
- 95 Williams DR, Cooper LA. Reducing Racial Inequities in Health: Using What We Already Know to Take Action. *Int J Environ Res Public Health*. 2019 Feb 19;16(4):606. doi: 10.3390/ijerph16040606. PMID: 30791452; PMCID: PMC6406315.
- 96 Magnuson KA, Waldfogel J. Early childhood care and education: effects on ethnic and racial gaps





