Diversity in Medicine: Why Our Patients Can't Wait

A Very Personal Perspective

Cherise Hamblin, M.D.
Obstetrician/Gynecologist
Penn Medicine LG Health Physicians Family & Maternity Medicine

INTRODUCTION

Throughout 2020, in the midst of a public outcry about videos of police killings of unarmed Black people, like that of George Floyd, many American institutions issued statements condemning racism. At the same time, diversity in medicine rose in the public's consciousness, with calls to action from diverse sources and generous gifts to historically Black colleges and university medical schools from Bloomberg Philanthropies. And yet, it is still rare to see a discussion of how the lack of diversity in medicine intersects with systemic racism.

For many industries, achieving diversity is simply good business. A diverse workforce can inject fresh, new ideas and foster innovation. Companies that embrace diversity and inclusion report higher engagement, lower turnover, and increased profits.[1] In medicine, however, the advantages of diversity are enhanced by even higher stakes: a diverse workforce saves lives.

PROOF THAT DIVERSITY IN MEDICINE SAVES LIVES

It has long been shown that minority physicians are more likely to enter primary care, and to practice in underserved communities. This tendency has been part of the strategy for alleviating the shortage of physicians in underserved areas for over 20 years. The experience has also taught us that diversity in medicine is linked to improved outcomes for minority patients.

A study in Oakland, Calif., showed that Black men who were seen by a Black doctor were much more likely to accept preventive and invasive services, and were more willing to talk about their health problems. Moreover, Black doctors were more likely to record extensive documentation about their Black patients. The authors estimated that "Black doctors could help reduce cardiovascular mortality by 16 deaths per 100,000 per year — leading to a 19% reduction in the black-white male gap in cardiovascular mortality." [2] Another study examined 1.8 million hospital births in the state of Florida between 1992 and 2015, and found that Black infants died at 3 times the rate of white infants.[3]

These findings are not imagined; they are documented and real, and for Black physicians they are personal

As a Black physician, I am particularly attuned to the need for diversity in medicine. In my own educational journey, I was often the only Black student in my science classes in college, the only Black student on my team in medical school rotations, or the only Black physician in my residency class.

The lack of diversity in medicine is often blamed on the talent pipeline. As Black students interested in medicine become accustomed to being "the only," we almost start to believe it. Then we meet peers, other students, and other physicians who share stories of being discouraged from medicine, getting costly advice (both financially and through missed opportunities), and being passed over for academic distinctions. I have come to regard being "the only" not as a badge of honor for the individual, but as a mark of shame for the institution.

I was first introduced to Lancaster in 1999, when I came to Franklin & Marshall College from the Bronx, N.Y. It was the first time I lived in a majority white environment and it was challenging, as well as the fact that I was one of the few Black pre-med students. While racial tensions did not run high at that time, the challenges I faced were of isolation.

I didn't connect with most of my science professors. I would watch peers build relationships, become teaching assistants and form study groups, but this was not my experience.

I had good professors; I got good advice; I didn't feel discriminated against. But I didn't feel like I belonged. Thankfully, I had a few key people who cheerleaded me on past the challenges that any pre-medical student faces, and a few key

experiences that helped me to embrace my calling to serve patients. By the time I finished residency, I knew that I was not a happy accident; several key circumstances had come together for me to persist in medicine. When I returned to Lancaster in 2011, and joined Family & Maternity Medicine, the hospital-employed Ob-Gyn group practice, I vowed to help more F&M pre-med students persist in medicine, and hoped that I could be particularly helpful to minority students.

I began working with pre-medical students and collaborated to create a mentorship program between F&M and Lancaster General Health. Physician Mentoring Opens Doors (PMOD) was started in 2013 by Dr. Daniel Weber, me, and the pre-med advisor at F&M. This program matched F&M students with physicians at LGH who were F&M alums to provide shadowing and mentorship. We started with a group of a dozen mentors. The program has since grown to include physicians throughout Lancaster, regardless of F&M affiliation. The College's student population has become much more diverse over the years, but I would routinely meet Black and Latino pre-med students who had never heard of the PMOD program. This program that I had helped build wasn't reaching the minority students.

I was meeting Black and Latino students who came to college knowing they wanted to become physicians, who were graduating but not going on to medical school. Their experiences were all too familiar. This wasn't an issue of lack of talent; it was leak of talent. These much needed future physicians were leaking out of the pipeline for a multitude of reasons. The pre-medical advisors, professors, and enrichment opportunities that were available were not reaching these students, who were and are so needed in medicine.

The increase in diversity among medical school applicants, matriculants, and graduates from 1980 to 2019 has not included Black or African-American applicants, matriculants, and graduates.[4] Black physicians have continually made up about 5% of the physician workforce for decades.

There is also a lack of progress in closing the gap in health outcomes between races. Since 2003, racial health disparities for Black people have not improved on 60 of the 73 measures of health care quality and access tracked by the Agency for Healthcare Research and Quality.[5] Only 10%-30% of the variance in cancer and chronic disease outcomes has been attributed to genetic factors, while the remaining 70%–90% has been attributed to the environment.[6,7]

We look at the social determinants of health for patients, but do we consider these factors in minority students and physicians? Black trainees and physicians are not immune to the outcomes we see in our patients. We may experience them personally and in our families, as well as in our patients.

From the first medical school lectures when professors described disease processes, as well as which populations have the greatest prevalence, the most severe disease, and the highest mortality, the punchline has always been me and mine. Black women. Black people. Now, during the COVID-19 pandemic, these trends are found again. To top it off, COVID-19 has coincided with a pandemic of police brutality that has shaken the nation and the world.

As a Black woman physician, this year's events have been particularly challenging for me. I have family members who, as essential workers, are overexposed and underprotected; I have talked family members through symptoms and tried to help them get access to testing; I have checked on family members who contracted COVID-19; and I have lost family members to the disease. The effect of COVID-19 on the Black community is personal to me.

As the nation woke up to what Black people have been experiencing in America, I have redoubled my efforts to affect the things within my power to change. For me, racial injustice and systemic racism are not issues of the day. They are facts of life, that even through my privilege as a physician, I must navigate. The way that a police officer, whose duty it is to protect and serve, can see a Black man as an immediate threat and be unable or unwilling to see his humanity, is personal for me. I fear for my husband and brothers if faced with a police encounter. I have stopped listening to the radio on the way to work, because the news of the day can completely derail my ability to focus, as it did with the news of the Jacob Blake shooting.

CONCLUSIONS

The disparate negative health outcomes affecting Black people in this country are personal to me, as is combating health disparities by increasing

diversity in medicine. When we say that we stand against racism and injustice, let us do more than examine our biases. Let us apply interventions where they are most needed and implement medical innovations for our patients with the worst outcomes. Let us educate, train, and recruit a physician workforce that will meet the needs of our patients, because patients can't wait.

Editor's note: *Dr. Cherise Hamblin is the founder of Patients R Waiting, a nonprofit organization dedicated to eliminating health disparities by increasing diversity in medicine. It has three areas of focus: increasing the pipeline of minority clinicians; making the pipeline less leaky by supporting students along their educational journeys; and supporting minority clinicians in practice.*

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Cherise Hamblin, M.D., OB-GYN
Penn Medicine Lancaster General Health Physicians
Family & Maternity Medicine
694 Good Drive, Suite 11
Lancaster, PA 17601
Phone: 717-544-3737
Fax: 717-544-3739
Cherise.Hamblin@pennmedicine.upenn.edu