Diversifying the Physician Workforce

To The Editor:

As a member of the Brown University Department of Dermatology Diversity Committee, I am quite cognizant of the challenges in developing more diverse resident and practitioner contingents. I applaud our colleagues in the Department of Orthopaedics for their multi-pronged outreach efforts in trying to balance their specialty in terms of gender, underrepresented minority (URM) and sexual and gender minority (SGM) representation, as noted in the article in the March issue of RIMJ, "Diversity, Equity, and Inclusion in Orthopaedic Surgery: Local and National Efforts," (http://www.rimed.org/rimedicaljournal/2024/03/2024-03-22-contribution-piana.pdf).

However, there may well be a ceiling that exists, above which continued efforts result in the law of diminishing returns. Several factors may lead to this. At the present time, many specialties are competing for the same small number of available individuals. Of particular note is that the absolute number of Black male applicants to medical school is currently less than it was three to four decades ago. Residency directors will be hard pressed to rectify this situation even with programs aimed at prospective high school students. Much of the solution for this falls more heavily on secondary education and medical schools. Without increased numbers of minority residency applicants, certain specialties will go begging no matter how hard they try.

An additional factor is the inherent nature of the different specialties and their attractiveness to different groups. For comparison, let's look at some demographics. Currently ObGyn has women at 87% of total practitioners, pediatrics is 74% female and my own specialty of dermatology is 62%. On the male-predominant side, Orthopedics is 80%, Interventional Radiology is 78%, and Neurosurgery comes in at 76%. One could claim that women have been relegated to the former specialties because of inhospitable residency programs in the latter. However, as with the construction trades, it may well be that the jobs themselves are more or less appealing to different groups. At the risk of dredging up objectionable stereotypes, I would note that in my graduating medical school class almost half of our rugby club entered orthopedics. The remainder of the class contributed a much lower percentage. This was at a time when women were only a very small percentage of those who matriculated, so while the observation is very anecdotal, it reflects not entirely unexpected male decisions. Individual preferences, therefore, may be somewhat true for other groups whether minority or not.

None of this should be taken to mean that the panoply of programs outlined by the orthopedists should be curtailed. But realistic goals may need to be set so that precious resources in both time and money are optimally utilized. One major concern of the diversity, equity, and inclusion (DEI) movement is that the lack of diversity in one's specialty output may deny the underserved adequate health services, due to social unfamiliarity with those populations, or the tendency to direct one's practice to those more like one's background. While it is certainly more comfortable to work with those with whom one is familiar, this is not a requirement. By and large we are a smart, empathetic bunch (or should be or we don't deserve to be in the positions we are in). It may actually make more sense for those specialties that tend to attract more homogeneous contingencies (i.e., orthopedics) to concentrate on developing expertise in supporting currently underserved populations as a matter of course.

Some of the examples of these efforts are as follows. The Brown Dermatology Department has given practical talks by residents and attendings in hair salons catering primarily to individuals of color about issues aimed especially at that population. Skin cancer screenings are done at South County beaches every summer. The RI Free Clinic is staffed on a regular basis by socially committed residents. The department also runs a continuously scheduled clinic for ACI inmates. Intermittent outreach is offered at the larger city organized street fairs in kiosks. Interactions with select high school students are done by interested attendings. The department is very cognizant of trying to incorporate medical students of traditionally disadvantaged groups as applicants in the interview process for our residency program. As has been found by our colleagues in orthopedics, this latter attempt may well be the most difficult given the relative dearth in the absolute numbers of individuals in the pipeline.

If indeed the specialties that tend to be somewhat monomorphous in terms of gender or ethnicity do not feel qualified to deliver optimal care to minority populations because of cultural awareness disparities, the skills necessary should be able to be acquired. All that is needed is the will. ❖

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Disclaimer

The opinions expressed by Dr. Glinick are his own and should not be considered those of the Brown Dermatology Diversity Committee.

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