The Importance of Diversity

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Sometimes the lines between medicine and politics can become somewhat blurry. I have been in many meetings for organized medicine where physicians have discussed whether their organization should take a stand on issues such as immigration, gun violence, parental leave, or climate change. In each case, the argument often comes down to the health issues involved in the larger societal issue. And in an issue like immigration, the value of diversity of the work force can also be raised.

In 2014, the House of Delegates of the California Medical Association directed the Board of Trustees to form a Diversity and Inclusion Technical Advisory Committee to develop a strategic plan of diversity and inclusion for the Association. They have done a remarkable job of looking at looking at ethnic and gender demographics of CMA membership and CMA leadership, and comparing it to general demographics of physicians in California, and looking at how these are changing over time (i.e. looking at various age cohorts) and how they compare to the general state population. They have found that although shifts in the physician community are occurring at a slower rate than in the general population, the face of medicine is changing, with medical school graduates being more closely representative of the general patient population. But even more interestingly, given that minority populations and other underserved populations experience poorer health outcomes, in this report they cite a number of sources that show that diversity in the health care workforce is integral to solving healthcare disparities. For example, currently underrepresented physicians are more likely to work in medically underserved areas and other underserved geographic regions. And ethnic-concordance and gender-concordance between physicians and patients is associated not only with higher levels of patient satisfaction, but also higher adherence to medical recommendations and patient health management. Among other examples, the report cited a specific example within Kaiser Permanent Northern California health care system where patients who switched from a language-discordant PCP to a language-concordant PCP saw significant improvement in glycemic control relative to patients who switched from one discordant to another discordant PCP. The report also reviewed some of the literature on Implicit Bias (see my article from 2017 on this topic).

I believe this report from the Diversity TAC to the Board of Trustees is part of a powerful argument that, as doctors, we do need to continue to get involved in some societal issues. Issues like discrimination and immigration can affect our patients not only directly, but also through affecting their ability to have diversity in their choice of doctors. In speaking up we can indeed be acting to promote better healthcare for the increasingly diverse population in California.

After every quarterly California Board of Trustees meeting I try to pick one item of interest to report on in this newsletter. While the "Report to the Board of Trustees from the Diversity and Inclusion Technical Advisory Committee" was not one of the largest agenda items, I thought it was both interesting and important. If you are interested in other topics discussed by the Board, or a general summary of the last CMA Board meeting, feel free to contact me at Barbara.yatesmd@gmail.com.
(Of note: after submitting this article on July 29, I saw in my email the AMA Morning Rounds Headlines on Aug 7 read "Women more likely to survive heart attack if ED physician is female).