Commentary: **Reflections on Diversity and Inclusion in Medical Education**

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Abstract

The authors discuss how the strategy of fostering greater diversity and inclusion regarding minorities can help decrease health disparities and improve health outcomes. They propose that examining admission to medical school of qualified individuals with physical disabilities and fostering better communication with these individuals should be part of that strategy. Whereas people with disabilities constitute about 20% of the population, only between 2% and 10% are practicing physicians. The two major barriers to having more persons with disabilities as medical students are the cost of accommodating these persons and medical schools' technical standards. The authors offer suggestions for overcoming these barriers, and the additional barrier of communication with persons with various disabilities, such as deafness or visual impairment.

The authors also discuss some of the issues involved in having greater representation of minorities in medicine. In addition, they stress the need for more training in cultural awareness for students and residents and for physicians well along in their careers. Medical educators will be increasingly called on to create new models designed to sensitize students and faculty to racial, ethnic, and other types of diversity, while documenting the efficacy and costs of extant ones, from the standpoint of both practitioner and consumer.

The authors hope that the moves toward greater diversity and more training in cultural awareness will increase the efficacy of health care while reducing its cost. The demands of these efforts will require the commitment of diverse, intellectually capable, and compassionate people at many levels of academic medicine.

Diversity is a multifaceted issue, encompassing gender, race/ethnicity, age, religion, socioeconomic status, sexual orientation, and disability. In this issue of *Academic Medicine*, there are 12 articles that mainly address important aspects of gender and race/ethnicity in the interest of decreasing health disparities and improving health outcomes. We have written this commentary not only to further discuss how greater diversity and inclusion regarding minorities can help attain these goals but also to propose that examining the admission to medical school of qualified individuals with physical disabilities and fostering better communication with these individuals can help foster those goals as well.

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Acad Med. 2012;87:1461–1463.
doi: 10.1097/ACM.0b013e31826b048c

Including Persons With Disabilities

In examining medical diversity, attention is naturally drawn to medical schools, where ample attempts at diversity and inclusion have been made. In 1997, the president of the Association of American Medical Colleges, Dr. Jordan Cohen, issued a moral challenge to the medical profession, saying that it was a "simple matter of social justice and equity" to take active steps to ensure that our health care practitioner community mirror society's gender, race, and ethnic mix, because, among other reasons, that would improve access to health care for the underserved.[1] Not long after, in 2000, the Liaison Committee on Medical Education introduced the standard for cultural competence in medical schools. However, in 2004, in an article in the *AAMC Reporter*, Dr. Cohen expanded the scope beyond race, ethnicity, and gender to include persons with disabilities.[2]

Eickmeyer and colleagues[3] observed that, since 2001, 0.56% of medical students matriculating and 0.42% of those graduating have a physical and/or sensory disability. These numbers are well below the proportion of the general population aged 18 to 24 with similar disabilities (3.5%). People with disabilities make up about 20% of the overall population, but only between 2% and 10% of practicing physicians. The two major issues that appear to remain as barriers to having more persons with disabilities as medical students are the cost of accommodating those persons and medical schools' technical standards.

Examining admission of individuals with physical disabilities to medical school is also, to borrow Dr. Cohen's words, a "matter of social justice and equity." Perhaps we should abandon the concept of the undifferentiated graduate, which assumes that all students have acquired the knowledge and skills required to enter any kind of residency program. The market for residency positions should be relied on to ensure that only students possessing specific physical abilities should end up in fields requiring those abilities. Technological advances, however, can often compensate for many impairments. Consequently, medical schools should consider these technological advances and revise their technical standards to eliminate barriers barring qualified individuals with physical and sensory disabilities.

The Americans with Disabilities Amendment Act of 2008 urges medical schools to reexamine the accommodation issue in a more positive manner with

respect to this underrepresented group.[4] The health care community has been called on to better define what constitutes "reasonable accommodation." In 2005, DeLisa and Thomas[5] proffered 10 recommendations to organized medicine regarding monitoring, supporting, and welcoming physicians with disabilities. Unfortunately, none of these recommendations have been followed. At the crux of the problem is that persons with physical disabilities are different from persons without disabilities, but being different is their "normal." It is hard for the nondisabled to realize this and thus meet the disabled on their own terms.

The program designed by the National Center for Deaf Health Research at the University of Rochester School of Medicine and Dentistry to address physician–patient communication with the deaf (described in this issue of *Academic Medicine*)[6] is particularly heuristic. If deaf people in Rochester experience "increased cardiovascular risks, intimate partner violence, and suicidal ideation,"[6,7] is it not reasonable to suggest that barriers to communication may be posing similar risks to the visually impaired, the culturally disadvantaged, and those with other communication disorders, such as aphasic disorders? It would be interesting to know if those struggling with compromised health issues such as these have unique systems of communication that would allow them to manage their own health problems if those responsible for their care could become more aware of those unique systems and use them to foster better health.

Delivering better health care to persons with disabilities and eliminating barriers barring qualified individuals with disabilities from attending medical school represent specific cases of the more generic challenges posed by the need to interface in multicultural settings. Much can be learned from the comparatively larger experience with cultural relativism by the international business community, as well as from the experiences of government, religious, and social service agencies.

Including Minorities

With regard to minority representation in the physician workforce, it is probably safe to say that it will increase owing to the liberalization of immigration laws, which could serve to reduce fear on the part of some qualified individuals who might have chosen continued anonymity. Ideally, increasing diversity in the physician workforce would help make that workforce more culturally competent and encourage enrollment of minority patients into clinical research trials. Even though the number of cultural awareness programs in medical schools has increased, this hardly closes the minority enrollment gap in residency training and continuing medical education settings for midcareer and beyond. These gaps must be closed, since changes in the structure of health care delivery will call for a much more culturally sophisticated physician. Also, physicians well along in their careers need to be more culturally sophisticated. What approaches should be employed to ensure the efficacy of cultural awareness programs designed for them?

Cultural sensitivity training is costly in terms of time, money, effort, and continued commitment not only by medical school faculty and administrators but also by funding agencies and state and local government officials. The effect of changes must be evaluated over time and deemed worthy of the cost on every level. Should we not be seeking also to assess the efficacy of such training, as well as of diversity programs, from the perspective of both practitioner and consumer? How do we concomitantly maintain focus on health outcomes, patient satisfaction, and compliance?

Pipeline programs beginning in high school, if not earlier, should encourage teachers and counselors to identify and screen youngsters of all cultural persuasions who give promise of possessing scientific acumen, passion, compassion, and the interpersonal skills essential to the provision of quality health care. (Admittedly, identifying that complex of qualities can challenge the most seasoned members of medical school admission committees.) Programs for students who have these qualities can help recruit diverse applicants and ensure that the most qualified applicants gain admission to medical school, a sine qua non in ensuring that even the poorest receive the highest possible level of care.

Our school, the University of Medicine and Dentistry–New Jersey Medical School, sponsors many programs for minority students, including a premedical honors program.[8] One aspect of the program includes randomizing students into separate seminar sessions conducted by our ethnically diverse medical student preceptors. It is common for students from the more affluent areas to express surprise when one of their less advantaged peers reveals that he or she has never been treated by a physician or dentist. The fact that this can happen illustrates one of the wide gaps that sensitive and informed training must bridge.

Summing Up

It is time to review some of the efforts designed to encourage the broadest possible student and faculty representation in our medical schools. The need for a review is enhanced by the recent Supreme Court decision upholding the liberalization of government-sponsored health care legislation, a signal decision that will increase demands on the health care system from a widening spectrum of our country. Although it is under serious debate, we hope that the move toward greater diversity, by including both minorities and also qualified individuals with disabilities, will increase the efficacy of health care. The demands of this effort will require the commitment of diverse, intellectually capable, and compassionate persons at all levels of academic medicine.

Medical educators will be increasingly called upon to create new models designed to sensitize students and faculty to ethnic, racial, and other types of diversity while documenting the efficacy of extant ones. Much can be learned by examining the efforts of other, nonmedical professions as they seek to sensitize their ranks within multicultural settings. More effort should be directed toward the creation of structured, formal education programs at the secondary and postsecondary levels for teachers and guidance counselors to help them identify and guide students in the myriad ways they can enhance their repertoire of early life experience conducive to successful careers in medicine.

Medical schools will find themselves challenged with increasing budgetary constraints and competition for curriculum time. Ethnic diversity training incurs expenditures of time,

money, and effort that will depend on enhanced commitment of educators and government officials alike.

A Recent Experience

We conclude by recounting a recent experience. Two underprivileged adolescent boys, after attending a lecture, approached one of us and extended their hands, seeking to introduce themselves, and remarked, "Wow, you're a professor." The feeling of pride in being a professor can only be surpassed by helping to give young people like these the same opportunities that we were once afforded.

Funding/Support: None.

Conflicts of interest: None.

Ethical approval: Not applicable.

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