The NEW ENGLAND JOURNAL of MEDICINE

Perspective

MARCH 9, 2023

Diversifying the Physician Workforce — From Rhetoric to Positive Action

Quinn Capers IV, M.D.

Despite compelling evidence that workforce diversity in medicine adds value to decision making, scientific inquiry, and care for an increasingly diverse patient population, the concept of recruiting qualified people from underrepresented backgrounds into higher education is controversial. Several U.S. states currently prohibit the consideration of race in higher education admissions, and the Supreme Court is reviewing cases that could lead to a decision banning this practice nationwide. Such a move could seriously impede efforts to recruit into medical school students from groups that have historically been marginalized or underrepresented in medicine (URiM) — including those who identify as Hispanic, Black, Native American, Native Hawaiian, Native Alaskan, or Pacific Islander.

Members of these groups who seek to enroll in medical school, match into residency programs, or obtain faculty positions tend to be attracted to institutions that model diversity and inclusion. But many institutions have struggled to recruit diverse students, trainees, and faculty. Although key strategies for diverse recruitment may not be new, they are not in widespread use — for multiple reasons, but largely owing to varying levels of commitment among and within institutions.

Though enhancing diversity is everyone's responsibility, senior leaders have a critical role in defining their institution's culture. At institutions where trustees, university presidents, deans, and department chairs stress the importance of a diverse workforce, diversity flourishes. I believe that leaders and their direct reports should be held accountable for the success or failure of attempts to enhance diversity. If department chairs were charged with increasing the hiring and retention of URiM faculty, residency program directors with increasing resident diversity, and deans of admissions with enhancing student diversity, and if their reappointments depended in part on success on this metric, institutions would adopt innovative strategies. I propose that institutions add "enhancing diversity" to the list of metrics for reappointment as a leader in academic medicine.

Another critical step is for selection committees to clarify unequivocally in their mission statements that persons from diverse backgrounds are valued, sought, and supported. These statements should be publicly visible to committee members and potential recruits and should guide the committee's actions, be reflected in interview questions, and influence the ranking of candidates.

Any selection committee hires or admits candidates on the basis of "merit," which should be defined in keeping with the stated mission. For medical schools seeking students who want to serve underserved populations, for example, applicants can be stratified according to their relevant past activities and potential for

continuing such service in the future.

At the undergraduate and graduate medical education (GME) levels, merit is often measured by standardized-test scores, course grades, and membership in honor societies. Though these metrics may predict performance on future standardized tests, they often have little to do with a program's mission to "advance surgical science" or "improve people's lives." A recent study found no differences in standardized-test scores between trainees selected as chief residents and their coresidents.[1] This finding suggests that stratifying residency applicants by test scores does not predict who will best exhibit the traits most coveted by training programs: clinical excellence, collegiality, leadership skills, and problem-solving skills.

Selection committees can start by deciding how they will define outstanding performance and using that definition to clarify "merit" and how it should evaluate candidates. My colleagues and I recently described a system for rating fellowship applicants in which merit was defined as evidence of clinical excellence, leadership potential, collegiality, academic curiosity, and "diversity competency," or potential for advocating for health equity in the field. Using this system led to increased racial diversity in the training program at our institution.[2]

Implicit bias can affect every stage of the recruitment and selection processes. From screening applications to rating interview answers to making final selections, even egalitarian-minded people may be influenced by biases based on race, sex, names (do they sound "foreign" or "ethnic"?), institutions, and physical appearance (including attire, skin tone, hairstyle, age, weight, perceived religion, etc.). Participation in interactive workshops led by experienced facilitators in which bias-mitigation strategies are rehearsed has been associated with increasing diversity among selected recruits.[3]

An expert panel convened by the National Institutes of Health highlighted best practices for successful bias-mitigation trainings, advising that sessions be voluntary and recurrent, provide actionable tasks for participants, be framed with positive messaging ("it is human to be biased, but we can overcome biases to treat everyone fairly" rather than "you are racist"), and be situated within an institutional framework for mitigating bias and enhancing diversity and inclusion. For medical school admissions committees and resident-selection committees, these trainings could occur annually; faculty-selection committees could undergo training before nominating and rating candidates.

At each stage of academic medicine, selection committees could actively recruit diverse applicants from the previous stage. Medical school admissions leaders should reach out to Hispanic-serving institutions (HSIs), historically Black colleges and universities (HBCUs), and tribal colleges and universities (TCUs), among others, to form recruitment pathways. The cooperative program between Brown University's School of Medicine and the HBCU Tougaloo College in Mississippi, in which competitive undergraduates at Tougaloo are offered early entry into medical school, is one example. Such cooperative programs begin with a meeting between stakeholders at the medical and undergraduate institutions to discuss common goals and the best interests of the premedical students. Before making this contact, leaders at predominantly White medical schools must recognize that recruiting students from these institutions may lead to a culture clash if their own institution is unprepared to support and nurture students from disadvantaged backgrounds and that culture change can be stressful. Efforts to enhance diversity should therefore be preceded or accompanied by initiatives to enhance a climate of inclusion, such as hosting organization-wide discussions about the benefits of diversity and cultural sensitivity training for faculty.

Similarly, GME leaders should visit HBCU or HSI medical schools, arrange virtual or in-person recruitment fairs, attend recruitment fairs held by diverse student organizations, and sponsor visiting clerkships. A recent report indicates that emergency-medicine programs that offer visiting student clerkships targeted to URiM students are more successful at attracting residents from underrepresented backgrounds.[4] Clinical leaders should also have a formal mechanism for recruiting their own residents and fellows from URiM backgrounds into faculty positions and helping them have a smooth transition into the role.

In searching externally for faculty candidates, universities typically post ads in medical journals and depend on their institutional prestige to attract interest — an approach that is unlikely to generate substantial interest among potential URiM candidates. I recommend also posting on websites that are likely to reach diverse candidates — such as those of the Society of Black Academic Surgeons, the National Hispanic Medical Association, and the Executive

Leadership in Academic Medicine program — and using search firms that are known to present diverse slates of candidates.

Efforts to inspire talented students from URiM backgrounds to pursue medicine need to extend to the early school years. In part because of structural and racial biases in society, children from underrepresented or disadvantaged backgrounds who aspire to be physicians are more likely than their peers to drop those aspirations before 12th grade.[5] Academic medical centers can help enrich the pool of students from diverse backgrounds who are prepared to pursue medical careers. Many institutions have community-outreach programs in which faculty or health-professions students interact with children and inspire them to achieve despite obstacles. Clinical skills laboratories in medical schools and teaching hospitals are ideal settings for proctored, hands-on activities for high school students. Programs that repeatedly expose children to such settings can result in more URiM candidates entering medical school.

An audio interview with Dr. Winfred W. Williams is available at NEJM.org

Programs affiliated with but independent of medical schools, such as the Young Physicians Initiative and Made for Medicine, that expose high school and younger students to medicine should be supported, expanded, and replicated to enhance the supply chain from the earliest stages. Ideally, such initiatives would be considered an essential community service for medical schools and teaching hospitals.

These strategies will succeed only with support from senior leadership, recognition and compensation for everyone involved in the work, and true acceptance that diversity is a value-added proposition in medicine and higher education. Ultimately, if academic medical centers don't find ways to enhance the diversity of the physician workforce, they will fall short of their mandate to improve the human condition.

Disclosure forms provided by the author are available at NEJM.org.

From the University of Texas Southwestern Medical Center, Dallas.

This article was published on March 4, 2023, at NEJM.org.

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DOI: 10.1056/NEJMp2211874

Electronic Prior Authorization for Prescription Drugs — Challenges and Opportunities for Reform

Jing Luo, M.D., M.P.H., and Walid F. Gellad, M.D., M.P.H.

On December 6, 2022, the Centers for Medicare and Medicaid Services issued a proposed rule to streamline the electronic prior-authorization process for medical services in the Medicare Advantage program.[1] The rule doesn't address outpatient prescription drugs covered under Medicare Part D, the program responsible for the bulk of Medicare drug spending. We believe congressional and regulatory attempts to modernize and streamline the prior-authorization process should include outpatient prescription medications, although such efforts would face many implementation challenges.

Prior authorization refers to the process whereby a clinician is required to obtain approval from a payer (e.g., a health plan) before a medical service can be covered. Prior authorization for prescription drugs serves an important purpose: it ensures that high-cost or high-risk medications are dispensed only to patients for whom they are clinically indicated. In some cases, prior authorization (along with other formulary-based tools) may give health plans leverage to negotiate larger discounts or rebates from drug manufacturers, thereby lowering overall costs for payers.

Despite the benefits of prior authorization for controlling prescription-drug spending and discouraging low-value care, however, the prior-authorization process is often burdensome for clinicians and has consequences for patients. In a November 2022 survey of 300 members of the American Society of Clinical Oncology (which advocates for prior-authori-