

November 11, 2009

President Barack Obama

The Honorable Nancy Pelosi, Speaker of the House

The Honorable John A. Boehner, Republican Leader

The Honorable Charles B. Rangel, Chairman, Committee on Ways and Means

The Honorable David Lee Camp, Ranking Member, Committee on Ways and Means

The Honorable George Miller, Chairman, Committee on Education & Labor

The Honorable John Kline, Ranking Member, Committee on Education & Labor

The Honorable Henry Waxman, Chairman, Committee on Energy & Commerce

The Honorable Joe Barton, Ranking Member, Committee on Energy & Commerce

The Honorable Edolphus Towns, Chairman, Committee on Oversight & Govt. Reform

The Honorable Darrell Issa, Ranking Member, Committee on Oversight & Govt. Reform

The Honorable John Spratt, Chairman, Committee on the Budget

The Honorable Paul Ryan, Ranking Member, Committee on the Budget

Greetings President Obama and the Esteemed Members of Congress,

We the undersigned, write to offer a representative voice of America's health professional students expressing our adamant opposition to the recent letter issued by the United States Commission on Civil Rights regarding several provisions of the America's Affordable Health Choices Act of 2009 (H.R. 3200), which were subsequently included in the Affordable Health Choices for America Act (H.R. 3962). Not only are we disappointed by the Commission's apparent failure to give due consideration to legislative precedents and compelling state interests, but we are appalled by the Commission's misrepresentation of the well-researched mechanisms proffered to achieve equality in healthcare. After the history-making vote on Saturday, November 7, we hope to ensure that the provisions to be discussed below remain a highly valued component of health reform legislation supported by the House of Representatives throughout the ensuing reconciliation process.

The H.R. 3962 provisions at issue are found in Division C (Public Health and Workforce Development), Title II (Workforce), Subtitle A (Primary Care Workforce), Part 2 (Promotion of Primary Care and Dentistry), Subpart XI (Health Professional Needs Areas) – specifically the proposed sections 2213 (d)(2), 2214 (e)(2) and 2215 (d)(2). The goals of these sections are to support and develop primary care training programs, train medical residents in community-based settings, and train dentists and dental hygienists, respectively. In each of these sections, grants and contracts to support these goals are to be awarded bearing in mind a number of preferences including, but not limited to, entities with a demonstrated record of training individuals who are from underrepresented minority groups or disadvantaged backgrounds. Given their context and structure, these provisions seem specifically aimed at updating the language of the US Code in the context of comprehensive

healthcare reform, as well as with a looming and complex primary care shortage facing our nation in the years to come.

One month ago, on October 9th, the US Commission on Civil Rights wrote to you, citing these aforementioned provisions as racially discriminatory and functionally misguided. In their letter, they allege that certain provisions in the bill appear to be designed to ensure that medical schools, dental schools and other institutions training health professionals will give preferential treatment in admissions to members of underrepresented minority groups. Though they acknowledge that the rationale for these provisions are rooted in the need to alleviate racial health care disparities, they express concern that (1) the shortage of medical professionals of particular races misdiagnoses, and could exacerbate, the problem of health disparities and (2) such Congressionally-mandated affirmative action is likely to be held unconstitutional. While the constitutionality of race-based admissions policies seems to provide their authority for commentary on the legislative provisions at hand, the authors spend the majority of their time attempting to refute the critical roles of a diverse health care workforce and cultural competency in improving the health care of racial and ethnic minorities.

In a response letter dated October 16th, the dissenting commissioners of the US Commission on Civil Rights expound upon some of the key issues. First, the October 9th letter (hereafter, the “majority letter”) objects to provisions already enacted into law by Congress through the Health Professions Education Partnerships Act of 1998. They assert that the provisions should remain as uncontroversial today as they were over a decade ago, as the references to “underrepresented minority groups or disadvantaged backgrounds” are not the only preferences for making grants. Next, they note that the legislation does not create a preference for minority owned contractors, and regard the invocation of *Adar and Constructors v. Pena* as a disingenuous and misleading parallel. Finally, they argue that the legislation does not create race-based admissions policies, as it does not require, nor does it encourage, race-based admissions.

With robust disagreement within the US Commission on Civil Rights itself, we respectfully defer to your wisdom to ascertain the account that best captures the spirit and potential impact of the aforementioned sections of H.R. 3962. However, as the next cadre of America’s health care professionals, we find it only appropriate that we focus our commentary on the role of diversity in medical education and its relative importance to the health of communities across our nation.

Racial and Ethnic Disparities in Health Care and Public Policy. In its majority letter, the US Commission on Civil Rights correctly notes that the gaps in life expectancy and morbidity rates that exist among racial groups in American are multi-factorial. After citing diet, exercise, life style differences, and genetic inheritance, they acknowledge that some of the disparities are the result of different medical treatment. To appropriately frame the discussion, we must note that the discourse regards these differences in treatment as *healthcare* disparities, to be

distinguished from inequalities in health status, alone—the more general *health* disparities. Within the scope of health care delivery, these healthcare disparities are due to differences in access to care, provider biases, poor provider-patient communication, poor health literacy, and other factors. This becomes an important distinction when we begin to discuss disparate outcomes as having some causal basis within the healthcare system itself, which could be alleviated through changes in policy to create a more equitable system for all.

The Agency for Healthcare Research and Quality (AHRQ) was mandated by Congress in 2000 to complete an annual National Healthcare Disparities Report (NHDR) to identify the differences or gaps where some populations receive worse care than others and to track how these gaps are changing over time.¹ The 2008 NHDR found that, for Blacks, Asians, American Indians/Alaska Natives, Hispanics, and poor people, at least 60% of measures of quality of care are not improving (either stayed the same or worsened). Similarly, for Blacks and Asians, 60% of the core measures used to track access remained unchanged (gap stayed the same) or got worse (gap increased). These failures to reduce disparities in healthcare were altogether distinct from the persistent inequalities in health status, which are purportedly due in part to individual level factors such as patient lifestyle and heredity. These failures, as noted in the 2008 NHDR, were failures of the American healthcare system to provide equally for its citizens regardless of race or ethnicity.

In evaluating the factors of causation for healthcare disparities, researchers for the NHDR evaluated the subjective healthcare experience of racial and ethnic minorities, particularly at the provider-patient interface. Poor provider-patient communication, the authors noted, can result from a number of complex factors, including a provider's lack of familiarity with cultural norms, language barriers, a patient's low health literacy, a chaotic work environment, and a lack of time during a visit. Poor provider-patient communication can lead to inefficient care and medical errors. Their analysis revealed that minorities are more likely to experience poor provider-patient communication. Moreover, minority patients are more likely to receive care in clinics where providers face workplace challenges and have a more complex patient mix. In their conclusions, the authors advised that addressing these health care disparities would require special attention to cultural attitudes and perceptions that affect health behaviors and patterns of health care access and utilization.

These findings of the 2008 NHDR were not novel, as they have been echoed throughout the health disparities discourse for the past decade. In fact, this was the basis for one particular recommendation in the Institutes of Medicine's landmark

¹ [National Health Care Disparities Report 2008](#). U.S. Department of Health and Human Services Agency for Healthcare Research and Quality; March 2009.

2003 report *Unequal Treatment*.² The authors felt that strengthening patient and provider relationships would also benefit from greater racial and ethnic diversity in the health professions. They cited studies that found that racial concordance of patient and provider is associated with greater patient participation in care processes, higher patient satisfaction, and greater adherence to treatment. Other studies indicated that racial and ethnic minority providers are more likely than their non-minority colleagues to serve in minority and medically underserved communities. Evidence of these benefits of diversity in health professions fields, the report noted, weighs in favor of strong commitments to affirmative action in medical school admissions, residency recruitment, and professional specialty training. They held an expectation that the benefits of diversity in the health professions will accrue broadly, as this diversity “helps to expand the disciplines’ ability to conceptualize and respond to the health needs of increasingly culturally and linguistically diverse populations.”

The Case for Diversity in Medical Education. In the US Commission on Civil Rights majority letter, the Commissioners make reference to the potential efficacy of health care workforce diversity recommendations, like the one cited above from *Unequal Treatment*, to eliminate racial and ethnic health disparities. To counter the claim that expanding the number of minority physicians and ensuring that all health care professionals receive cultural competency training would help remedy the problem, they cite the testimony of Dr. Amitabh Chandra of Harvard University who, at a briefing before the Commission, suggested that this view is “grounded in hope more than science.” Given the theme of misrepresentations throughout the majority letter regarding the corpus of health disparities research, you should not be surprised to find that Dr. Chandra’s opinion exists in the minority.

In 1970, the Association of American Medical Colleges (AAMC), the non-profit association representing all accredited U.S. medical schools, asserted that special attention should be paid to minority groups underrepresented in medicine, and that minority groups should be represented in medicine in the same proportions as in the population as a whole.³ The need to ensure a diverse medical school classroom as outlined by the nation’s leading authority on medical education and medical admissions nearly forty years ago, speaks to the relevance and impact such practices can have on the future of healthcare in this country.

As of 2009, the AAMC continues a concerted campaign to increase diversity in medicine. In a publication entitled “America Needs a More Diverse Physician Workforce,” the AAMC regarded the critical need for more minority physicians as one of the most pressing health care challenges facing the nation. In the next 15 years, while the nation is projected to confront an overall shortage of physicians, the

² Smedley BD, Stith AY, Nelson AR. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Institute of Medicine, New Academies Press. Washington DC; 2003.

³ Petersdorf RG, Turner KS, Nickens RW, Ready T. Minorities in Medicine: Past, Present and Future. *Academic Medicine* 1990; 65(11): 663-670.

need is, and will continue to be, particularly great for minority physicians. Statistical projections suggest that by 2050, racial and ethnic minorities are projected to account for half of the U.S. population—a statistic that only compounds an already pressing provider shortage in minority communities.

Research indicates that physician diversity addresses health care disparities in at least three important ways. First, it helps to improve access to care. Studies show that minority physicians are more likely to treat minority patients and indigent patients and to practice in underserved communities. For example, the AAMC annually surveys graduating medical students about their career plans. The 2004 results of that survey indicated that about one-fifth of all graduates planned to practice in underserved areas, including nearly 51 percent of African American, 41 percent of Native Americans, and 33 percent of Hispanic/Latino graduates. By comparison, only 18 percent of white graduates had similar intentions.

A second way that physician diversity addresses health care disparities is in increased patient satisfaction. Studies also indicate that when minority patients can select a health care professional, they are more likely to choose someone of their own racial and ethnic background. Relationships between patients and physicians of the same race or ethnic background also are characterized by higher levels of trust, respect, and the increased likelihood that patients will recommend their physician to others.

Finally, a diverse physician workforce helps to ensure culturally competent care. Despite the claims of the US Commission on Civil Rights in its majority letter, the nation *does* need a culturally competent health care workforce—that is, one with the knowledge, skills, attitudes, and behaviors required to provide the best care to a diverse population. Exposure to racial and ethnic diversity in medical school contributes importantly to the cultural competence of all of tomorrow's doctors. A diverse student body brings an array of ideas to the learning environment; helps students challenge their assumptions; and broadens their perspectives regarding racial, ethnic, and cultural differences.

This final point was echoed by a September 2008 study published in the *Journal of the American Medical Association* entitled *Student Body Racial and Ethnic Composition and Diversity-Related Outcomes in US Medical Schools*. Saha, et al. found in their survey of over 20,000 medical students across the nation's non-Historically Minority Medical Schools, that when there was a more positive climate for interracial interaction and exchange of diverse perspectives, majority students' cultural competence was positively impacted. Additionally, the study found that white students who attended more racially diverse medical schools rated themselves as better prepared than students at less diverse schools to care for racial and ethnic minority patients, having stronger attitudes about inadequate access to

health care.⁴ The impact on student perception and attitudes toward patients and their practice environment speaks to the asset that diversity is both in medical education and in physician-patient interactions.

Moreover, the AAMC has compiled a targeted action plan for Academic Health Centers, with their first three recommendations being: (1) Increase the racial and ethnic diversity of the U.S. physician workforce, (2) Increase medical trainees' exposure to underserved settings (3) Increase knowledge regarding segregation of care and disparities⁵. The commitment within medical education to set guidelines and provide recommendations for educational practices, speaks to the impact that this issue will have on the training of future physicians. Legislative support promoting the implementation of said recommendations will realize a patient inclusive and provider consistent reform of healthcare in America.

The Impact of Workforce Diversity on the Health of Minority Communities.

In the US Commission on Civil Rights majority letter, they call into question the value of diversity and cultural competency among doctors in actually achieving better outcomes in racial and ethnic minority patients. Citing evidence presented to the Commission, they assert specifically that black doctors are not more likely than white doctors to provide black patients with the highest level of care. They make claims that “the problem lies with the fact that, as a population, black patients use different doctors, clinics and hospitals than white patients. On the whole, the doctors who treat black patients with frequency are less likely to be highly credentialed and more likely to report obstacles in gaining access to high-quality service for their patients. As one might expect, these circumstances can lead to poorer health outcomes.”

This becomes the basis for their argument that more “quality physicians” rather than “diverse physicians” would be the key to improving the health of minority communities. It follows, then, that if increasing racial and ethnic diversity in American medical schools would lead to schools lowering their academic standards, as the majority asserts, then it could actually further exacerbate the disparities in health care in these communities rather than serve as an effective remedy.

The reality, however, is that the health status of minority patients is less easily attributed to the race of their provider than it is to other, more proximate causes. For instance, high-minority physician practices (that is, practices with a patient

⁴ Saha S, Gupton G, Wimmers PF, et al. Student Body Racial and Ethnic Composition and Diversity-Related Outcomes in US Medical Schools. *Journal of the American Medical Association*, 2008; 300(10): 1135-1145

⁵ Addressing Racial Disparities in Health Care: A Targeted Action Plan for Academic Medical Centers. Association of American Medical Colleges 2009.

population exceeding 70 percent black or Latino) are in communities with lower patient income and more uninsured individuals. Additionally, physicians with more minority patients report greater difficulty obtaining specialty care for their patients. Moreover, physicians with high-minority patient panels are more likely to be in community or public clinics and institutional practices. Consistent with physician reports of inadequate time with patients, office visits in higher-minority practices were notably found to be shorter. When looking at the differences in primary care physician characteristics for practices with low, medium, and high proportions of minority patients it was found that those physicians treating high-minority populations were much less likely to be the practice owner, had spent fewer years in practice, and were more frequently international medical graduates. With such multi-factorial causation plausible simply from physicians' subjective accounts of their experience with minority populations, it is all the more absurd that the majority letter attempted to attribute the disparate patient outcomes largely to physician race and ethnicity.

Still attempting to devalue the role of diversity in the physician workforce, the US Commission on Civil Rights majority letter referenced an oft-cited study on cardiac catheterization, which found that black patients were significantly less likely than white patients to undergo cardiac catheterization within 60 days after admission with an acute myocardial infarction. Of note to the majority Commissioners, the authors in this 1998 study found no significant interaction between the patient's race and the physician's race, indicating that black patients treated by black physicians did not undergo cardiac catheterization at a different rate from black patients treated by white physicians. They did, however, overlook some widely held criticisms of this study, as stated in *Unequal Treatment*:

Data on the race of the attending physician were missing for nearly one-third of the initial patient sample. In addition, African-American patients were more likely to be cared for in public or teaching hospitals, where greater barriers exist to receipt of catheterization, such as the availability of the procedure on-site. The most serious methodological problem, however, was the determination of the race of the attending physician ("the clinician who is largely responsible for the care of the patient from the beginning of the hospital episode"). Upon closer examination, it becomes apparent that the African-American physicians of these patients tended to be internists, not cardiologists, when compared with the white attending physicians. While these physicians may all refer patients for the procedure, the determination of who receives the procedure is typically made by the cardiologist. Thus, the authors compare two different physician pools who cared for these African-American patients post-myocardial infarction—African-American internists versus white cardiologists—to assess differences in utilization of a procedure that is specifically performed by and managed by cardiologists. Notably, of the nearly 20,000 cardiologists in the United

States during the study period in 1994 and 1995, only 316 (approximately 1.5%) were African American.

Again, with such a paucity of African American cardiologists reflecting a similar underrepresentation of minority physicians in general, we must recall the scientific data supporting the positive impact that such diversity would have on the provider-patient interaction for racial and ethnic minorities. The role of diversity in American medical schools has a statistically supported cohort effect on our physician population, and remains a viable and important element of the robust effort that must be undertaken to appropriately strive for equity in health care.

Conclusions made by the Sullivan commission and other collaborators are resolute in their position that in order to increase diversity in the health professions, the culture of medical education must change.⁶ Novel and altogether non-traditional paths to the health professions for underrepresented minorities and disadvantaged students should be explored in education at all levels, necessitating a legislative commitment to meet societal needs. Eliminating health disparities requires a strategic, multifaceted approach that incorporates changes in medical training, appropriate attention to social determinants of health, and finding appropriate remedy for any biases that may impact the receipt of the best health care for all Americans.

Through our respective student organizations, we have done our part to advocate for diversity in medical education, address the unmet needs of our patients, and alter the consciousness of our future workforce. Indeed, we live by the assertion that it takes far more than textbooks to adequately prepare a physician to be a servant of all. We applaud these and other thoughtful provisions of H.R. 3962 and are uncompromising in our charge to ensure diversity among primary care physicians and in the health care workforce as a whole. We encourage the legislature to continue to create even more pathways for persons of different backgrounds and experiences to become health care professionals. We seek your undeterred partnership as we aim to create diversity in our classrooms with the ultimate goal of increasing access, ensuring quality, and promoting equality—thereby ensuring true civil rights for all.

Respectfully Submitted,

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⁶ Sullivan Commission on Diversity in the Healthcare Workforce. *Missing Persons: Minorities in the Health Professions*. A Report of the Sullivan Commission on Diversity in the Healthcare Workforce, 2004.

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