Med School Diversity Sways Health Care Concepts

BY DAMIAN McNAMARA
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White students attending more racially diverse medical schools consider themselves better prepared to care for patients of racial and ethnic minority groups than are students at less diverse medical schools, according to a study of more than 20,000 graduates.

Attitudes about providing equivalent access to health care for everyone also were stronger among students at more diverse schools. These students' responses were 50% more favorable toward equitable access to care, compared with their counterparts at the least diverse schools.

The associations were particularly strong at medical schools that foster positive interactions and sharing of opinions among students from different backgrounds, Dr. Somnath Saha and colleagues reported in a recent issue of JAMA (2008;300:1135-45).

The investigators also found a "threshold effect" regarding minority student enrollment. Specifically, diversity outcomes were positive among the 118 medical schools in the study if the proportion of underrepresented minority graduates (URMs) exceeded 10%, or the total nonwhite student population was more than 36%. The authors had no financial conflict-of-interest disclosures relevant to the study.

Policies and programs devised to achieve racial diversity in medical schools and to increase the numbers of underrepresented black, Hispanic, and Native American students "have come under increasing scrutiny as being unnecessary and discriminatory," the authors wrote. Dr. Saha is an internist at the Portland VA Medical Center and Oregon Health and Science University.

Affirmative action and addressing prior injustices are the justifications for most programs to increase URM student diversity, However, Dr. Olveen Carrasquillo and Dr. Elizabeth T. Lee-Rey wrote in an editorial in the same issue of JAMA, "the well-documented history of widespread racism within organized medicine and the American Medical Association's apology is a reminder of how pervasive and tolerated such practices were only a few decades ago" (2008;300:1203-4).

In the current study, Dr. Saha and colleagues assessed results of the online graduation questionnaires administered by the Association of American Medical Colleges in 2003 and 2004. They assessed anonymous responses from 20,112 individuals, representing 64% of all graduates during those 2 years.

Race and ethnicity were self-reported. The 9% of URM respondents included black, American Indian, Alaska Native, Mexican American/Chicano, mainland Puerto Rican, and Native Hawaiian students.

Minorities not considered to be underrepresented in the physician workforce, primarily Asians and non-URM Hispanic or Latino students, comprised the 23% nonwhite/non-URM group. The remaining 68% were white students.

'Medical schools may need to actively foster positive interaction among individuals from different backgrounds to derive the benefits of diversity.'

A total of 21% of the 13,764 graduates in 2003 and 22% of the 7,472 graduates in 2004 strongly agreed that "everyone is entitled to adequate care." Also, 42% of the 2003 graduates and 44% of the 2004 graduates strongly agreed that "access to care is a major problem."

A total of 59% of the 2003 cohort and 60% of the 2004 cohort indicated they felt prepared to serve diverse populations.

Interestingly, white students at more diverse medical schools did not indicate they were more likely to care for underserved populations. "This may reflect confounding by the urban versus rural location of schools," the authors wrote. "Rural schools are likely to have both fewer nonwhite students and more students who plan to practice in rural, underserved locations."

In contrast, a total of 49% of URMs planned to work with underserved patient populations, significantly more than both white (19%) and nonwhite/non-URM students (16%).

"The finding by Saha and colleagues in this issue of JAMA that…increased medical school diversity is associated with white students feeling better prepared to care for diverse patients is an important contribution to the medical literature," Dr. Carrasquillo and Dr. Lee-Rey wrote.

"Findings from this methodologically rigorous study can inform efforts to elicit continued support by the Supreme Court for admissions policies favorable to URM diversity." Dr. Carrasquillo is director of the Center for the Health of Urban Minorities at Columbia University Medical Center and Dr. Lee-Rey is codirector of the Hispanic Center for Excellence, Albert Einstein College of Medicine, both in New York.

"As with all cross-sectional studies, there are important limitations, the most important of which is the inability to address causality," Dr. Carrasquillo and Dr. Lee-Rey wrote.

Dr. Saha and colleagues noted that they had no measures of student attitude, experience, or plans to practice medicine prior to entering medical school.

In addition, schools that actively recruit a diverse student body might be more committed to improving diversity-related outcomes, another possible confounder of the study.

"A diverse student body is likely to be necessary but not sufficient. Medical schools may need to actively foster positive interaction among individuals from different backgrounds to derive the benefits of diversity.

"Two overarching questions remain," Dr. Carrasquillo and Dr. Lee-Rey wrote. "First, is more evidence needed to justify increased medical school diversity? No, but it might help. Second, why have medical schools not been able to tackle this important challenge? There may not be a genuine commitment by academic leaders toward increasing URM diversity, so that it may be more about having the will than finding the way." ■

High Physician Suicide Rates Suggest Barriers to Treatment

BY JANE ANDERSON
Contributing Writer

Studies over the past several decades have confirmed that physicians—especially women physicians—die by suicide more frequently than people in other professions or those in the general population.

"Physicians have the means and the knowledge and access to ways to kill themselves," said Dr. Paula Clayton, a psychiatrist and medical director for the American Foundation for Suicide Prevention, in an interview.

But the data on physicians dying by suicide are difficult to come by, and "we certainly don't have any data that [say] any particular specialty has any higher rates of suicide," Dr. Clayton said.

Although no information is available on the risk of suicide by specialty, researchers do know that physician suicides are equally divided between men and women, whereas in the general population, four times as many men kill themselves as do women, according to Dr. Clayton.

Awareness of the problem remains low, and professional and cultural barriers deter or prevent physicians who are depressed from seeking treatment for their illness, Dr. Clayton said. For example, most physicians do not have a regular source of health care; only 35% of doctors have a personal physician, and even fewer interns and residents have a doctor themselves.

Dr. W. Gerald Austen, surgeon-in-chief emeritus at Massachusetts General Hospital, has first-hand experience with physician suicide. Twenty-eight years ago, when he was surgeon-in-chief, one of his younger staff committed suicide. And about 11 years ago, a surgical resident committed suicide.

Those two deaths were the two saddest moments of his career, yet Dr. Austen said he doesn't know what the department and the hospital could have done to prevent these young physicians from taking their own lives.

"It wasn't as if the institution and the department weren't aware that they had some problems," he said in an interview. "Both of these individuals were under psychiatric care. They were believed by both their doctors and their contemporaries and colleagues to be doing rather well."

In each case, the surgery department reviewed the situation with the psychiatry department, Dr. Austen said, and "we certainly did everything we could in terms of their family in both cases." But he said the department didn't find any procedures to change internally as a result of the deaths.

It's possible that increasing awareness of physician depression could help get physicians the help they need before it's too late, Dr. Austen said. "Friends who work with people in medicine need to be aware that, if they see something that concerns them, they need to transmit the message to the powers that be."

But it's difficult to know the difference between someone who is simply unhappy, and someone who is clinically depressed and potentially at risk for suicide, he added. "[Physicians believe] their job is to help other people with problems. If they have a problem themselves, they would prefer to not have people know about it," said Dr. Austen.

"There's this proudness about their ability to cope," Dr. Clayton said. "They are reluctant to seek help because they fear the stigma will harm them—people won't refer them patients, the hospital might revoke their privileges, and licensing could become a problem."

State medical licensing boards ask for information on whether the person applying for licensure has been treated for a mental illness, and that information can affect licensing, she said. "I worked with a physician who took lithium," she said. "The state board made him get blood drawn periodically to prove he continued to take it. That's punitive—they don't do that for other illnesses."

However, some progress has been made in reducing the stigma: A total of 19 states now focus specifically on whether an applicant is impaired because of psychiatric illness, she said.

Dr. Clayton's group recently funded the production of three films on physician suicide as part of an ongoing outreach campaign that seeks to educate physicians about depression. The goal is to help them better recognize the symptoms in themselves and their patients while also cultivating a more thorough understanding of mood disorders in the community at large.

One of the films was designed specifically as an educational video for use at medical schools. Because many of the mood disorders that can lead to suicide might become evident first during medical school, where professional and institutional barriers already exist, the goal of that program is to encourage medical students to seek help for depression.

Good treatments exist, Dr. Clayton said. "The treatment clearly is antidepressants and psychotherapy that focuses on your problems. There's very good short-term psychotherapy for depression—even for bipolar disorder." ■