A Call for Data Collection on Underrepresented in Medicine Population Groups

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In the United States, the health professions have long struggled to achieve a diverse workforce reflective of the greater population they serve. Within the medical profession in particular, the Association of American Medical Colleges (AAMC) has projected a deficit of racial and ethnic representation of up to 124,000 physicians over the next 10 years.[1] To take one example, Black Americans account for 12% of the current U.S. working age population, but only 5% of the physician workforce. The statistics are similar for many other population groups that are underrepresented in medicine (UIM).[2]

The Council on Graduate Medical Education (COGME) is concerned about the ongoing lack of diversity within the medical profession, reflecting insufficient numbers of UIM medical students, residents, practicing physicians, and medical scientists and faculty. In a previous letter, the Council discussed some of the contributing factors as well as the human impact related to this lack of diversity and proposed steps to create safe and fair learning environments for all medical trainees and improve the retention and advancement of UIM clinicians and faculty.[3]

This document highlights the need for concrete action to better measure medical trainee and physician workforce composition over time. These data would inform efforts to increase the recruitment of UIM individuals into medical careers, and to illuminate factors contributing to the loss of UIM individuals during the long process of medical education and training, vital steps needed to strengthen the physician workforce by improving retention and promoting diversity.

Improving Measurement

We cannot improve what we do not measure. To improve diversity and inclusion in medicine, the federal government, which funds most of the graduate medical education (GME) programs in the country through the Centers for Medicare and Medicaid Services (CMS), the Department of Veterans Affairs (VA), and the Health Resources and Services Administration (HRSA), among others, must establish standardized and accessible data platforms. There are currently multiple healthcare workforce data repositories managed and maintained by both federal and non-federal entities. For example, the HRSA Data Warehouse website (data.HRSA.gov) provides maps, reports, and dashboards to the public about HRSA's health care programs and the health care workforce. As another example, the Accreditation Council for Graduate Medical Education (ACGME), which accredits all GME programs in the United States, collects a wide range of data on medical residents and faculty. However, access to this data is limited, in part due to the risk of data misinterpretation or even exploitation, which could create barriers to educational initiatives that promote diversity.

As a result, the various data sets are disconnected. They lack standardized definitions and collection methods, interoperability, and transparency across clinical delivery, medical education and accreditation, health care delivery, health workforce policy and planning, and federal funding and oversight agencies. Without clear, consistent, and reliable data, well-intended stakeholders in medical education and health care delivery systems lack shared methods to assess the current state of the medical education pipeline and the physician workforce, along with accepted metrics of accountability and success.

COGME Recommendations

COGME believes that one critical step toward achieving diversity in the physician workforce is the development of a standardized and validated uniform healthcare workforce data set. This data could serve to offer a clear assessment of the current state of the workforce, provide accountability for programs intended to improve diversity, and create the basis for metrics of success in achieving a diversified workforce. By charter, COGME is responsible for "assessing physician workforce needs on a long-term basis, [and] recommending appropriate federal and private sector efforts necessary to address these needs." To achieve these aims, COGME recommends that Congress authorize and fund HHS to:

1. Complete an environmental scan of physician workforce data repositories of federal, accrediting, and professional agencies and define federal jurisdiction to establish an interoperable universal federal repository for mandatory reporting of longitudinal GME pipeline data by all federally funded GME programs. Data should include demographics of medical students, residents, and faculty, practice patterns post-graduation, along with the reason(s) for any trainee departure or termination.
2. Build on the work of the National Academy of Sciences, Engineering, and Medicine[5] to convene inclusive GME stakeholders to define the repository's validated, consensus-driven, and standardized core uniform data set of relevant longitudinal health workforce pipeline metrics. Invitees should include federal GME funding agencies (CMS, VA, and HRSA), ACGME, AAMC, the American Medical Association, and intentionally selected leadership representation of osteopathic and allopathic medical schools, as well as traditional academic medical center and Teaching Health Center accredited sponsoring institutions.
3. Integrate the standardized core metrics of physician workforce diversity into the Healthy People 2030 framework; invest in longitudinal research studies of healthcare workforce pipelines and practice patterns to assess the impact of federally funded workforce development and mentorship programs on these metrics.

Conclusion

A single data repository with shared contributions and ownership and broad accessibility will require close collaboration across governmental, accrediting, and professional agencies. As envisioned by COGME, data from this repository can better guide policies and programs to diversify the physician workforce, leading to broadened access to care, enhanced patient satisfaction, decreased health disparities, and improved public health.[4]

References

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