Perceptions Revisited: Pediatric Chief Resident views on Minority Housestaff Recruitment and Retention in Pediatric Residency Programs

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Financial Disclosure: The authors have no conflicts of interest.

Purpose: This study examined institutional strategies among pediatric residency programs for recruitment and retention of underrepresented minorities (URM) housestaff.

Procedures: A questionnaire developed by the authors in a 1992 study was modified and then mailed to 185 pediatric chief residents at non-military pediatric training programs in the United States. Descriptive statistics (means and frequency) were calculated for each question. There were three rounds of mailings and a telephone follow-up.

Main Finding: The response rate was 39% (n=73). Thirty-eight percent reported that URM housestaff recruitment and retention was a priority for their program directors, 37% reported that it was a priority for themselves, 25% reported it was a priority for the hospital administration, and 36% reported that they were not sure about the priority of URM housestaff recruitment and retention within their organization. Sixty-seven percent stated that their housestaff selection committees do not have defined recruitment goals, 6% indicated that their committees have specifically defined recruitment goals, and 27% were not sure.

Conclusions: Despite numerous initiatives from government agencies, medical institutions, and institutions of higher education, a critical gap remains among institutions in their recruitment efforts for URM at the level of residency training. Our study suggests that pediatric chief residents may not be adequately educated or primed regarding the importance of recruitment and retention of URM. As individuals involved with both medical training and hospital hierarchy, they are uniquely positioned to influence and carry out program goals and objectives.

Key Words: Pediatrics ■ residency programs ■ minorities

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INTRODUCTION

Achieving increased levels of racial, ethnic, and cultural diversity in the United States health care system remains an explicit goal for many medical educators and for the institutions where they work. Although the U.S. is becoming increasingly diverse, the physician workforce is not keeping pace in terms of reflecting the composition of the populations served. Approximately 30% of the U.S. is comprised of individuals from groups underrepresented in medicine, or underrepresented minorities (URMs).[1] According to The Association of American Medical Colleges (AAMC), URMs are defined as individuals who are African American, Hispanic/Latino Americans, and Native Americans (including Alaskan Natives and Native Hawaiians).[2] Although African American and Hispanics/Latino populations are growing, they have remained noticeably underrepresented within the physician workforce.

A 2004 Institute of Medicine (IOM) report cited a continuing shortage of URMs among healthcare professionals.[3] In 2008, ethnic minorities made up approximately 28% of the U.S. population, but accounted for only 8% of practicing physicians.[1, 4] This imbalance is predicted to worsen with the projected increase in our nation's diversity in the population. By 2050, URMs are projected to compose approximately 48% of the U.S. population.[5,6,7] According to the IOM report, increasing the ethnic diversity among healthcare professionals must remain a priority because diversity has been associated with improved access to care for ethnic minorities, greater patient choice and satisfaction, better patient-clinician communication, and improved educational experiences for students.[9]

Historically, numerous initiatives have been suggested by various branches of government, educational governing bodies, organizations, and institutions to improve racial and ethnic diversity within higher education.[9] Strelnick, et al., highlighted our nation's affirmative action history that began with President Kennedy's Executive Order 10925 in 1961.[10] Subsequently, the AAMC in 1969 established an Office of Minority Affairs that partnered with the National Medical Association, the American Medical Association, and the American Hospital Association to increase the representation of minorities within medical schools to a goal of 12% by 1975.[10] Between the years 1970 and 1975, these efforts were nearly successful: the enrollment of URMs increased from 3% to 10%.[11] Although the AAMC and other entities were making progress with diversifying U.S. medical schools, anti-affirmative cases that started with DeFunis v. Odegaard in 1974 were beginning to negatively impact the admissions policies of academic centers.[12, 13] Several cases regarding the constitutionality of using race as a factor in the admissions policies of undergraduate and graduate institutions were brought before the U.S. Supreme Court, with various rulings.[14,15] Of note, in 2003, Grutter v. Bollinger was a pro-affirmative action decision to allow the university to utilize race and other factors in their law school's admission practices. Most recently, at the time of this writing, the ability

to use racial status in the admissions process at institutions of higher learner has resurfaced at the Supreme Court with the Fisher vs. Texas case. [16]

Despite the various views expressed in legal decisions, the AAMC has continued to develop partnerships and implement strategies to foster diversity within the medical community. The goal of Project 3000 by 2000 was to increase the number of URM matriculants annually from 1,485 in 1990 to 3000 by the year 2000.[17,18] This goal was not met, and despite numerous initiatives to build diversity in medical education, the progress has been slow. In 2009, 15% (n=2,496) of U.S. medical school graduates were from URM backgrounds.[19] More recent programs include the AAMC's Holistic Review for Admissions, which encourages admissions committee members and academic institutions to consider ethnicity, race, and other factors such as socioeconomic status, educational background, and sexual orientation.[20] Educational governing bodies such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME) also have enacted policies to promote diversity in the workforce and to offer cultural-competency training of medical trainees to better equip them for providing health care to a diverse patient populations.[21, 22]

To this end, physicians at all levels of medical education may not be aware of their institutions' efforts to recruit and retain URM house staff. In a previous study involving pediatric chief residents conducted nearly 20 years ago, most of them (>70%) stated that they were not aware of their resident recruitment committees' specific goals to increase the racial or ethnic diversity within their residency program.[23] Other authors used qualitative research methods to capture the experiences of African American residents and identify their perceptions of how racism, discrimination, and social isolation impacted their training experiences.[24] Due to the ongoing concerns that the diversity of our physician workforce is not keeping pace with the changing racial and ethnic composition of our nation, we repeated the survey conducted nearly two decades ago to re-examine the strategies used by pediatric residency programs to recruit and retain URM house staff.

METHODS

This study used a survey questionnaire first developed by the authors of the 1992 study. In 2010, the researchers modified the survey and sent surveys to 185 pediatric chief residents listed in the Medical Association (AMA) 2010-2011 Directory Graduate Medical Education (GME) of non-military pediatric training programs in the continental U.S. The survey sought information on the size and the metropolitan status of the training program, the patients they served, the number of minority faculty and house staff in the program, chief residents' understanding of minority recruitment policies, support structures at their institutions, and opinions related to URM recruitment issues. A subset of the 2010 responses was then compared to the 1992 responses, for the institutions that answered both surveys. In the 1992 study, a 28-questionnaire survey was mailed to pediatric chief residents from 78 non-military pediatric training programs listed as having 35 residents or more in the American Medical Association (AMA) 1992–1990 Directory Graduate Medical Education (GME). The 1992 survey design was reviewed by the institutional review board (IRB) at that time, and the current study secured IRB approval as well.

DATA ANALYSIS

Data analyses were performed using SPSS (versions 19.0) and STATA IC (version 12).[25] Descriptive statistics (means and frequency) were calculated for each item on surveying instruments. A subset of the 2010 data was then compared to the 1992 data using statistical procedures appropriate to the nature of the item, which included Shapiro-Wilks test for normality of the data, Paired t-test for comparing numeric data, Fisher's Exact Test to compare frequency counts, and Mann-Whitney Test for ordinal data comparisons.

RESULTS

After three rounds of mailings and telephone follow-ups, the response rate for the 2010 survey was 39% (n=73).

Characteristics of Residency Programs and Institutions

As shown in Table 1, the mean number of pediatric beds at the institutions surveyed was 146 (range, 16-466). The mean number of full-time pediatric faculty was 81 (range 0-420). Among the institutions where the pediatric residents trained, the majority of patients provided care in both inpatient and outpatient settings were from urban areas. Table 2 shows the racial mix of patients, faculty members, and house staff at training institutions. The patient populations provided care by residents showed racial/ethnic diversity. Approximately 60% of patients were African-American or Hispanic. By contrast, only approximately 16% of full-time faculty and 16% house staff were African American or Hispanic. The large majority (63%) of residents in all PL years were White.

Chief Residents' Perceptions of Recruitment and Retention

Table 3 summarizes chief residents' perceptions of priorities on house staff diversity. Among the chief residents surveyed, 38% reported that minority house staff recruitment and retention was a priority for their program directors and 37% reported that it was a priority for themselves. The chief residents rated the hospital administration the lowest for prioritizing resident diversity. Little more than 25% of chief residents reported that minority house staff recruitment and retention was a priority for the hospital administration, whereas approximately 39% reported that they were not sure.