

Recommendations to Accrediting Agencies for Increasing Racial and Ethnic Diversity in the Health Professions

Excerpt from (Wagoner, Johnson & Jonas, 2004)

"The authors make recommendations as to the development of **new accreditation standards**, **strengthening** of existing ones, and ways in which accreditation, with effort and collaboration among health care leaders, will ultimately **result in a diverse** U.S. health-care **workforce** commensurate with a diverse population."

- “1. Recommendation. That accrediting bodies undertake a strategic planning process that gives strong consideration to reaffirming the social contract as an obligation of the educational institution.

2. Recommendation. Given the Supreme Court ruling on June 23, 2003, medical schools should team up with other health professions to discern how to effectively work within the law to find ways in which to increase diversity in the admissions process.

3. Recommendation. Accrediting bodies should carefully review existing standards and develop more specific references to racial and ethnic diversity both in the student admissions processes and in faculty recruitment.

4. Recommendation. That high-profile organizations such as the IOM, Department of Health and Human Services, CHEA, ASPA, LCME, and ACGME, along with key foundations and health professions' organizations, convene for the purpose of (1) agreeing upon a core set of competencies that includes diversity and cultural competency, and (2) developing a clear and uniform definition of the core competencies.

5. Recommendation. That accrediting organizations translate the core competencies into standards. Individual accrediting bodies (nursing, medicine, etc.) would need to work out the details of standards that focus on best practices for their disciplines.

6. Recommendation. Accrediting organizations should require universities and their health-care programs to revise their mission statements to include more specific references to racial and ethnic diversity, cultural competency, and culturally appropriate care for diverse populations. Such standards could further suggest including faculty developmental processes to enhance the teaching of cultural competency.

7. Recommendation. Leaders from different health disciplines should meet biennially to promote ways to integrate the core competencies into health professions education.

8. Recommendation. Accrediting bodies should develop standards mandating that institutions/programs incorporate cultural competency into the curriculum. Because some of the

other health professions' standards already emphasize the importance of teaching cultural competency (reviewed later in this paper), collaboration on best practices could be especially helpful in devising effective standards. Such standards should require that schools/programs incorporate curricular elements that involve continuous, first-hand experiences with diverse patients. The school/program would need to include how it intends to assess whether the teaching and experiences offered did in fact increase cultural competency.

9. Recommendation. That accrediting bodies devise new standards that address ways in which institutions/programs can better judge student readiness in areas of professionalism, communication, and interpersonal skills. Accrediting bodies should work closely with licensing agencies that test for core competencies in graduates of health professions programs in the process of change, such that as new core competencies are developed, these might be included in assessments for licensure. Testing that has consequences always serves as a powerful incentive, particularly when the reward centers on achieving licensure, certification, or recertification.

10. Recommendation. Once new standards have been established, accrediting bodies could offer national workshops or seminars to schools/ programs that would review the intent and meaning of the new standards. In addition, the accrediting bodies could create a website that lists key resources and best practices and offers opportunities to site visit programs that showcase best practices. To keep the public aware of efforts being made, the website could contain results of yearly research in education that offers the latest in assessment or development of new information on health and illness in various ethnic and minority groups.

Analysis and Recommendations Regarding the Five LCME Accreditation Standards on Diversity

Five LCME standards pertain specifically to diversity. A brief discussion of each follows, along with recommendations. The authors have taken into consideration whether site team visitors can easily analyze those standards requiring specific outcomes and means of assessment.

1. ED–21: “The faculty and students *must* demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases and treatments.”

Although this standard has as its goal a very well intentioned outcome, its double-pronged approach, directed toward both faculty and students, renders it virtually ineffective. Most schools have few, if any, provisions on how to effectively abide by the standard relevant for both. The ability to measure outcomes for this standard remains marginal; even the best informed LCME site visitors have no way to assess whether both faculty *and* students have met the cultural competency (understanding) as set forth. In all likelihood, the visiting team's focus would center

on assessing the types of cultural competency curricular programs available for students and the content of faculty development programs being offered to address this issue.

11. Recommendation. Considering the intent and scope of this standard, we recommend crafting standards directed toward achieving the two separate outcomes currently stated in ED–21 and developing measurable outcomes to assess cultural competency (understanding) in the separate standards.

Having been a site team visitor to several institutions, this author (Wagoner) suggests that once the LCME has strengthened existing standards and instituted new ones, the organization provide a more comprehensive training program for site visitors on how to properly interpret standards.

2. ED–22: “Medical students *must* learn to recognize and appropriately address gender and cultural biases in themselves and others, and in the process of health care delivery.”

This critically important standard essentially speaks to the matter of trust, a subject much discussed in health professions' literature. Trust in the doctor-patient relationship can only be established when physicians overcome preconceived biases and acquire insight and understanding into another person's values, beliefs, and needs. In the article, “Trust, Patient Well-Being and Affirmative Action in Medical School,” DeVille highlights the importance of trust, calling it “central to the individual physician's ability to practice good medicine.” He notes that minorities' historical and current experience with the medical profession and health delivery system frequently breeds suspicion rather than faith. He concludes: “Society and the medical profession have a compelling interest and duty to produce physicians who inspire trust” (DeVille, 1999, p. 247). Although schools can be cited for noncompliance of this standard, this author (Wagoner) knows of no institution that has been cited for failure to achieve the outcome specified by ED–22 or for lacking a mechanism by which to assist individual students in overcoming biases.

12. Recommendation. Standard ED–22 hinges on the development of measurable core competencies. Once accrediting bodies have developed the core competencies, they should place a high priority on determining how the competencies are being achieved. An array of assessment instruments could furnish this information.

3. MS–8: “Each medical school *should* have policies and practices ensuring the gender, racial, cultural and economic diversity of its students.”

This broad-based standard acknowledges the LCME's commitment to the stated goal of diversity in students entering medicine, although the standard is weakened by use of the word “should”

rather than “must.” The intention of this standard mirrors that of dentistry in its focus on the recruitment and retention of diverse students. At present, site visit teams can assess the school's admissions selection process and the extent to which diversity exists by evaluating medical school data. Therefore, unlike the previous two standards, this one has outcomes that can be measured by specific instruments. However, as written, the standard fails to acknowledge the importance of diversity in the context of a quality education or in the quality of health-care access or delivery for an ever-increasing diverse population.

13. Recommendation: Reframe the standard to emphasize the importance of having a diverse, culturally competent workforce in order to provide the highest quality health care. Ensure that the standard's wording is changed from “should” to “must” in all current and newly created standards.

The subtext of this standard states: “The extent of diversity needed will depend on the school's missions, goals, and educational objectives, expectations of the community in which it operates, and its implied or explicit social contract at the local, state and national levels.” This subtext gives institutions tremendous latitude to gear their policies and practices toward their current missions, goals, educational objectives, and social contract, which may be woefully inadequate to create a diverse student body or to train medical students to be racially, culturally, and gender sensitive. Unless an institution's leadership has a strong commitment to the goal of diversity, achieving this standard in its full measure will be a matter of circumstance rather than advocacy.

4. MS-31: “In the admissions process and throughout medical school, there *should* be no discrimination on the basis of gender, sexual orientation, age, race, creed or national origin.”

14. Recommendation. That the word “should” be replaced by the word “must.”

This standard encompasses verbiage found in most medical school admissions handbooks that puts them in compliance with the Equal Employment Opportunity Commission laws disallowing discrimination in the admissions process on the listed bases. Although well intentioned, the standard provides no means of determining whether schools/programs are conforming in the admissions process, particularly in how they handle/consider/recruit individual candidates. Assessment by LCME site visitors at this microlevel would be well beyond the purview of their responsibility. In essence, they have to trust the school's word that it is in compliance.

15. Recommendation. In order to provide measurable outcomes, this standard needs to require (1) that each school/program publish yearly statistics regarding its class diversity,

and (2) that each institution/ program have its mission statement readily available for inspection by students so that those seeking an institution that values diversity could more effectively target their applications. This sort of public accountability also would enable patients to recognize programs that have a commitment to creating a diverse workforce.

5. FA-1: “The recruitment and development of a medical school's faculty *should* take into account its mission, the diversity of its student body and the population it serves.”

For the past three decades, the number of women on medical school faculties has increased. The 2001 AAMC Faculty Roster source shows that women constitute 32.6 percent of U.S. faculty (AAMC, 2001). However, the same has not been true for minorities, whose number does not come close to reflecting the patient population or, in many instances, the student population at any particular medical school. In the IOM Symposium on Diversity in the Health Professions entitled *The Right Thing to Do, The Smart Thing To Do*, in his chapter on “How Do We Retain Minority Health Professions Students?” Dr. Michael Rainey stated, “There is a severe shortage of underrepresented minority (URM) faculty teaching core courses. Although African Americans, Native Americans, Mexican Americans, and Mainland Puerto Ricans make up almost 25% of the U.S. population, they account for less than 8% of all practicing physicians. Only 3% of medical school faculty members belong to one of these minority groups.” In 1989, URM faculty represented only 2.9 percent of clinical faculty in U.S. medical schools (Rainey, 2001).”

SOURCE:

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