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Increasing Inclusivity in the Workforce: A Look at Diversity in Rheumatology

Announcer:
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Dr. Dua:
A recent data analysis indicates that not only are we facing a shortage of rheumatologists, but also that our workforce does not reflect the demographic of our patients.[2,3] This obstacle, together with the shortage, provides an opportunity to cast a broader net to help make our workforce more diverse and inclusive.

This is ReachMD and I am Dr. Anisha Dua. Joining me to discuss diversity and inclusion in the rheumatology workforce are Drs. Grace Wright and Dr. Irene Blanco. Dr. Wright is a consultant rheumatologist in New York City and President of The Association of Women in Rheumatology, AWIR. Dr. Wright, thanks for joining us today.

Dr. Wright:
Thanks for having me, pleasure to be here.

Dr. Dua:
And Dr. Blanco is a professor and associate dean for diversity enhancement in the Department of Medicine at the Albert Einstein College of Medicine. Dr. Blanco, thank you as well for being here today.

Dr. Blanco:
Thanks so much for having me.

Dr. Dua:
Of course. So, Dr. Blanco, let's level set our current understanding of the rheumatology workforce. Based on your experience, how diverse or representative really is it?

Dr. Blanco:
So, the rheumatology workforce is not incredibly diverse, and I think that's just honestly representative of the entire medical workforce. So, for example, most physicians come from the top socioeconomic brackets of the United States.[4] And in general, while rheumatology is gender skewed much more towards women,[5] so we see many more women within the overall workforce, we do see that in positions of leadership, it's predominantly men.[6] And then subsequently women often are on clinical educator tracks which are incredibly important because we're teaching the new generation, right, of rheumatologists. But those tracks often don't lead to positions in administration, don't lead to division chief positions, etc. and are often lower paying positions and positions where you may potentially, not necessarily are able to segue into broader leadership across rheumatology.

Dr. Wright:
And we see this as well, Dr. Blanco, across many industries. It's called that middle management fall-off, that cliff, so that you can rise from entry to sort of junior right to middle and then suddenly, what I call it is, women rise, they stop and then they drop. And so, that the leadership line is really taken over by the male colleagues and this is something that we see across multiple, but particularly in medicine and especially in rheumatology.[6]

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Dr. Dua:
Yeah, that's disturbing but true. So, with that in mind, Dr. Wright, what are some of the barriers, you think, to diversifying the workforce that are impacting this representation in rheumatology?

Dr. Wright:
Yeah, so let me start off with a skewed representation then you need more than mentorship, you need sponsorship. You need people who are going to be at the top, pulling people through. Not just telling them how to be better, but opening the doors, holding their hands, and walking through.[6] So, the fewer of whoever the underrepresented group is, whether we're looking at a gender you know, race, whatever that is, the fewer there are, the harder it is to get sponsorship. But that's what sponsorship is.

And then the idea that implicit bias being pulled through here again, women have been told from when they were little girls all along, that they are lesser, that they are not as good at science, that they are not as good at leaders, that they should bow to. And so, in many situations, we disincentivize women to really go for that leadership. We have to stop telling our young women that they don't qualify so they shouldn't apply. They qualify and they should apply. And we should help them get those qualifications and move forward.

Dr. Blanco:
You know, and there's various groups in rheumatology that face so much bias and discrimination. So, you know, Dr. Wright just brought up women, but also, we see a lot of foreign medical grads in rheumatology. We have a lot of workforce shortages and it's a way for us to bring in new fellows to really train and incorporate FMGs into our practice. But so many of them have horror stories, right, whether it's bias from patients, you know, saying, "Well, do you even speak English? I don't want this foreign doctor," etc. Or sometimes being held pretty much hostage in their training situations because of visa requirements, etcetera, um, with threats of even deportation. I mean my program does take a lot of foreign medical grads and I have heard horror stories from my trainees on situations that they faced throughout their training by the time they get to me.

Dr. Wright:
Absolutely and then something that is disquieting to my soul, is that these foreign trained fellows or trainees are actually the ones who are more likely to resemble the very patients that we're trying to pull in, in a diverse and inclusive manner. And if we can't even empathize and connect with our colleagues, who are more like us than dissimilar, just based on a variety of touch points, how then do we extend that to our patients?

So, we can't really speak out of both sides of our mouth. You know, we can't say there's diversity and inclusivity that we want for the patient but not for our coworkers. And I think these are things that we have to face within medicine, within rheumatology.

Dr. Dua:
Yeah, absolutely and it's not just the attitudes, it's this entire infrastructure that we really need to sort of dismantle and figure better ways to deal with.

What sort of, outside of the issue, what do you think if we could fix a lot of these problems and barriers, trying to integrate international medical graduates in a more diverse workforce period into rheumatology training? Dr. Blanco, what do you think that impact would be if we could diversify this workforce? How do you think that would impact patient outcomes?

Dr. Blanco:
Well, I think, diversity in the workforce is often to linked to health equity. And I think that, you know, when you bring in physicians from diverse populations, you're in essence, bringing the voice of said populations into now, the other upper echelons right into the rooms where decisions are made. And I think that, you know, as we then diversify our workforce, it's going to open up a lot of perspectives on the pathways and how patients view sort of medicine and understand treatments, etc.

You know, for example, translation services, right? We're starting to use more iPads, etc. because translate, if you just use the phone, the translator over the phone can't really translate tone, can't translate demeanor, can't really translate all of the things that you are seeing in the clinical encounter. Oftentimes, things get missed, colloquialisms and then different expressions. So, if you start to bring in physicians from different populations, you're going to pick up a lot more nuance and probably have a lot more engagement, where the patients just feel like they can relax because they have a doctor that really gets them on a different level.

Dr. Wright
And when we think about the impact on the person's outcome, we find that when there is better concordance whether that is through cultural humility or in fact, there is a concordance between the culture as whether it's, you know, a Black to Black people of color to people of color it really doesn't matter.[1] One study actually showed that Black men who saw Black healthcare providers did more of the preventative health measures.[7]

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So, it means that the health of the community was augmented because we had better cultural concordance. So, this is something that we can feed into our interaction so that there's a greater alliance between the healthcare systems, patients, and their wellness.

And I always go back to say the definition of health equity implies that we set a standard, we provide an effort on action in order to achieve an outcome that is equity. So, if we want our patients to do the work of wellness, we really have to build in all of this in there so that they can do that heavy work for a future gain, not a gain that they may feel today, but in 10 or 20 years. It's an investment in health.

Dr. Dua:
Absolutely, and I think, you know, we've touched on the importance of trying to diversify the workforce, you know, where we stand right now, and how that would really truly impact patient outcomes and not only just the trainees that we're trying to work with but also patients in a very real and tangible way.

So, let's talk a little bit about we can try to overcome some of these barriers we're talking about. Dr. Wright, what are some ways that you can think of that we might be able to improve diversity and inclusion in our rheumatology workforce so that we can move towards some of these better outcomes that we just touched on?

Dr. Wright:
Yeah, we've got to create a pipeline, right? And the pipeline starts before college. It starts before high school, because that child in middle school has to be told that yeah, you can do science. You can learn biology and chemistry and pull them all the way through, the same way that we have programs that mentor young children all the way through into business, or engineering, or other things. We should really invest in that, starting in our very early education. So, get kids into science, get them excited about healthcare as a positive thing. Health is not just about being sick. Health is actually about being well, in spite of the various hurdles that we have.

Dr. Blanco:
So, you know, once they get to medical school, that's not the end of the journey. Just being a medical student in and of itself is extremely expensive. All of the tools that you'll need to study for Step 1, Step 2, applications to residency. Right now, because of COVID, we're not traveling as much, but once we start actually doing in person residency applications, how will students from poor socioeconomic status fly out to the different programs, get hotel rooms, get a new suit, etc.? We really need to think about that entire pathway. You know, how are we treating our Black and Brown students? What biases are they facing, right? And think about then, not through medical school but through the entire path, right, into senior positions of leadership.

Dr. Wright:
Yes, and we really do need these corporate educations partnerships. We need to fund these core strategies because money doesn't come out of thin air. And, you know, we can't just sort of globally say it's okay to get into debt. It's not okay for many of these students to assume debt.

And the other thing as you mentioned, Dr. Blanco, is that we mentor these young students all the way through but remember that if you're coming from a majority population, mentoring somebody from an underrepresented population, it may look very different for that group of people.

And so, there is no 1 way to mentor. And it's not about me mentoring according to the style that is comfortable for me, it's me mentoring in a style that helps my mentee. It's about them, not about me and so we have to start to be really culturally responsive to understand the things and the areas that will be important to all of our students.

Dr. Blanco:
And, you know, there's training for this and so we can actually train and mentor our mentors so that they can become better mentors. The Center for Improvement of Mentoring Experiences in Research, it's more tailored to PhDs and post-docs but it's an enormous resource out of the University of Wisconsin that can really help teach mentors how to be better mentors. And, for us to start bringing programs such as those into MD and more clinical tracts, I think will really help in order to create that mentoring and that sponsorship that these trainees are going to need to succeed.

Dr. Wright:
Absolutely, because it's about understanding the value systems of that culture. And then using that to improve our mentorship.

Dr. Dua:
Absolutely. I think you guys have gone such a clear job of explaining sort of all of the different levels and layers of barriers that folks face in becoming rheumatologists, right? Like us talking today. And so how do they get here? It is a really layered path with a lot of barriers and I think we've started to discuss some ways we can try to offload that, get people connected with the health system early understand that these are opportunities that they actually can pursue, they deserve to pursue and then not only just mentor them but sponsor them

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all the way through to try to get them where they need to be.

So before we close, any final thoughts from either of you? Dr. Blanco, any take-away messages for our audience?

Dr. Blanco:
I think the biggest take-away on my part is to really think about your applicants, your trainees, your colleagues more holistically. Take a chance, really think about the characteristics that these people bring to the table, and realize just how your patients maybe desperate for those characteristics to be seen in their providers, right? It's not just about metrics and board scores, like, really think about who these people are and how they're going enrich your environment.

Dr. Dua:
Wonderful. Dr. Wright, any final take-away messages from you?

Dr. Wright:
Well, I'll leave us with a food metaphor. A salad with only one fruit is actually not a salad, it's just a fruit that's been cut up. So, diversity brings richness and if we appreciate the richness of a diverse population in our patients and in our students, then it enhances all of us. So, it's not just as Dr. Blanco said, checking a box, it's really including everybody so that all of us benefit from a richer experience.

Dr. Dua:
That's wonderful, you've inspired me and made me hungry. It's a great way to round out our discussion here on this topic. I really want to thank my guests here for helping us better understand diversity and inclusion in the rheumatology workforce. Dr. Wright, Dr. Blanco, it was really a pleasure speaking with both of you today.

Dr. Wright:
Pleasure to be here.

Dr. Blanco:
Thanks so much.

Announcer:
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