

## *Virtual Mentor*

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### **ART OF MEDICINE**

#### **The Face of Contemporary Medicine: Is It Diverse?**

Sam Huber

When the first AMA House of Delegates convened in 1901, its membership was largely homogeneous. It is no surprise that most American physicians were white males, and after the emergence of medicine as a profession these gentlemen were, on the whole, financially secure. Neither should it be a surprise that the demographics of today's delegates and of the profession are vastly different. One could say that the profession has achieved diversity relative to its composition 100 years ago. Some would argue that this is not enough. They would argue for categories of difference in addition to color, gender, and financial status in the name of improved patient care. Although the causal link between a diverse physician population and quality of patient care seems intuitively correct, it remains tenuous and unproven.

A recent study defined diversity for medical school students along 9 population characteristics: age, sex, race, ethnic background, physical disability, religious affiliation, sexual orientation, socioeconomic status, and rural background (town population of < 5000)<sup>1</sup>. AAMC data on medical school applicants and matriculates tracks sex, race or ethnic background<sup>2</sup>. A cursory examination of these data suggests that these demographics have not changed appreciably over the past 10 years.

As we stretch the collective discussion of diversity to include more characteristics, the broader categories become divided into more specific descriptions. Narrowing the categories of diversity to gain specificity increasingly detaches these subgroups from reality and from the realistic goal of improving patient care. The danger is that skepticism and subdivision can rapidly collapse into individualism, the notion that everyone is distinct or (even worse) unique, and that categories don't work for anyone. For example, if the only means to the end of better patient care becomes one-to-one physician/patient concordance and familiarity, the ideal paradigm would be a physician treating family members, an untenable and unethical position. In seeking concordance, the opposite of diversity is achieved if the discussion results in individualized and segregated sameness.

Yet, despite the above stretching and dividing process, it is important to assert that some differences matter. (Sometimes, the lack of differences matters, too, as in treatment protocols or standards of care.) In the presence of similarity, differences become defining and distinguishing characteristics. Human functioning is in large

part based on the recognition of such differences. The difficulty is in assessing which differences are useful in a certain situation. A medical approach to variation often assesses symptoms or differences on the basis of functionality. Such a distinction applied to statements about diversity informs a process of heuristic management, wherein a heuristic is a generalization that is functional, and a stereotype, one that is not.

The questions to be asked are which differences matter enough to receive a privileged (or perhaps protected) place in American medicine and medical education, and to whom these differences matter, be they actual patients, potential patients, or physicians in training in an attempt to foster habits or virtues. Perhaps race and gender are no longer the differences that matter the most. Surely, they were paramount issues in the history of medical demographics, and they may still be important to consider. It is also important to consider what differences need to be protected because respect for them is not intuitive. The reason to protect or ensure that a category of difference will be present in medicine or medical school is that it stretches our understanding and capacity to connect with people and their ideas. If diversity is a dialectic growth process and not a battle, perhaps we should consider where next to grow, rather than considering whether one group has won some sort of battle for inclusion.

### References

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2. AAMC Data Warehouse. Available at: <https://www.aamc.org/data/facts/start.htm>. Accessed November 26, 2001.

Sam Huber is a research assistant in the AMA Ethics Standards Group.

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