Diversity in Physician Assistant Education
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Throughout the history of the physician assistant (PA) profession there have been many educators, leaders, and programs that have demonstrated support for the principles of diversity in higher education long before those principles were defined. Early efforts to educate and prepare providers to serve diverse populations and areas of need in the nation have, in part, shaped a philosophy that has made the PA profession a leader in quality health care and patient advocacy. This article outlines a few of those efforts and addresses future directions for diversity within PA education that will continue the profession’s leadership role in a time of diversity and change within the nation’s health care system.

INTRODUCTION
The physician assistant (PA) profession has grown out of a need to increase the United States medical workforce in order to improve access and quality of care for the nation’s residents and underserved communities. The United States is a multiracial, multiethnic country, in which the ethnic diversity increases daily. It is predicted that within the next 50 years, no racial or ethnic group will be the majority of the US population. To accommodate these rapidly changing demographics, the decisions PA educators make must continue to take into account the impact of our national diversity. This article will examine some of the historical trends of diversity as it relates to PA education and discuss future directions for positive outcomes.

Diversity in health professions education serves many purposes. A diverse health care workforce can decrease health disparities by increasing access as well as quality of health care, through congruence. A diverse workforce brings a variety of perspectives and experiences to the classroom and clinic, allowing PA students and faculty to benefit from interaction with individuals having backgrounds different from their own and providing a wider range of potential for research. This article addresses diversity in PA education in the areas of student enrollment, cultural competency curriculum, and organizational leadership.

TRENDS IN PA EDUCATION AND OTHER PROFESSIONS
The history of PA education has strong parallels with issues of diversity in higher education that started in an era of profound social change in our nation. The training of PAs in the early years was, in part, shaped by the outcomes of policies that arose from the civil rights movement.

With the primary mission of providing health care to areas of the nation with limited access to care, a diverse workforce was an important early consideration for PA programs. Many of the first programs received federal funding that was awarded with the intent to increase the number, diversity, and geographic distribution of primary care providers. Not long after the first programs were established, PA programs began receiving federal funding via the Comprehensive Health Manpower Training Act (CHMTA) of 1971 to enhance primary care education and distribution as well as to increase the number of underrepresented minorities in the PA profession.

When compared to other health professions schools, PA programs had a higher percentage of underrepresented minority students enrolled in their programs during the 1980s and 1990s. Figure 1 shows the percentage of different minority groups enrolled in each of the health profes-
sions schools, against the percentage of those groups in the general popula-
tion. It should be noted that the data for public health schools and PA pro-
grams include Asian subpopulations that were not reported as “underrepre-
sented” minorities by allopathic and
dentistry schools for data sets shown.
The reason for the higher percentage of minority enrollment in PA pro-
grams may include the profession’s his-
torical philosophical mission, the early
influence of federal policy, and the
early establishment of PA programs in
institutions and hospitals traditionally
serving underrepresented minorities.3,1

Recent studies indicate that the percentage of PAs and certified nurse
practitioners working in rural and medically underserved areas is higher
than that of physicians in certain
states.9,10,11 This outcome may be in
part due to the enrollment patterns of
underrepresented minorities in PA
programs, relative to those of other
professions.8,2 These practice patterns
are encouraging and demonstrate that
the PA profession can play a crucial
role in addressing the nation’s health
disparities. Despite this relative suc-
cess, there need to be ongoing efforts
to increase the diversity of students
enrolled in PA programs so that our
future health workforce will more
closely resemble the racial and ethnic
composition of the nation.

ORGANIZATIONAL HISTORY OF
DIVERSITY

Minority Student Programs

Prentiss Harrison became the first
African American PA graduate when
he graduated from Duke in the class of
1968.10 By 1971, three PA programs
were established in urban African
American community hospitals, with
the purpose of training African
Americans and other minorities to
work in those and similar communi-
ties. In 1974, Howard University start-
ed the first PA program in a historically
black university. The Howard
University, Harlem Hospital, and
Charles Drew University programs are
credited with graduating the majority
of African American PAs in the cur-
rent workforce. These programs were
recipients of early funding from the
CHMTA.

In the 1970s, the Indian Health
Service (IHS) utilized two IHS hospi-
tals, one in Phoenix, Arizona, and the
other in Gallup, New Mexico, to train
Native American and Alaska Natives to
serve their communities.14 Malcolm X
College/Cook County Hospital, Miami
Dade College, and Bronx Lebanon
Hospital began as programs serving
predominately minority student popu-
lations over a decade starting in the
late 1980s. Today there are several PA
programs dedicated to increasing the
number of minority PAs and that
accept high numbers of minority stu-
dents.

Committees, Initiatives, and
Leadership

Within the Physician Assistant
Education Association (PAEA, former-
ly the Association of Physician
Assistant Programs, APAP), there has
been consistent commitment to
addressing issues of diversity. The
Association’s Committee on Ethnic
and Cultural Diversity (CECD), origi-
ally the Minority Affairs Committee
(MAC), has addressed issues of diver-
sity in PA education for many years.
The MAC was initiated in the 1980s by minority faculty who wanted to increase the number of underrepresented minorities in PA education. In 2000, after considerable discussion, MAC became CECD. During this time many other professional organizations were changing the names of similar committees to more general names, such as Committee on Diversity, to reflect a broader definition of diversity. There was pressure within PAEA to do the same. However, MAC committee members and many other faculty did not want to lose the focus and organizational momentum that had brought some of the issues of minorities to the forefront. Thus, the current name was agreed upon.

In 1987 the APAP MAC, under the leadership of Brenda Jasper, started Project Access at the APAP national conference. Project Access was an outreach program in which minority PAs who attended APAP and AAPA meetings addressed youth audiences in minority neighborhoods of the host city conferences. The intent of the project was twofold: (1) to raise awareness of the PA profession for young people and (2) through the PAs’ personal stories, to provide inspiration for these young people to continue in school. Project Access continued for a decade, undergoing several changes over the years.

Two reports, entitled *Presentation on Minority Attrition Data on Nine Physician Assistant Programs and Minority Retention Programs*, were issued in 1996 and 1997.15,16 These reports were produced by MAC committee members for PAEA through a contract with the Bureau of Health Professions (BHPr). The reports “explored the determinants of minority attrition and retention in PA programs as well as developed recommendations for decreasing attrition and enhancing retention.”15 The latter report identified successful strategies used for graduating minority PA and health professional students. Both reports were to serve as resources for PAEA programs and faculty to use to increase the racial and ethnic diversity within the PA profession. Following the reports, the MAC presented the Minority Issues Faculty Development Workshop, a 2-day workshop to help PA faculty facilitate PA education for “diverse and minority PA students,” at the PAEA Annual Education Forum in Milwaukee, Wisconsin, in 1997. The workshop issues included culturally sensitive curriculum; faculty roles in facilitating educational environments supportive of cultural differences; addressing PA program culture and processes that address recruitment, retention, and curriculum; the role of community partners; and clinical placements in promoting a diverse learning environment. This workshop was also part of the BHPr PA Workforce Faculty Development Contract with PAEA and was a precursor to the Association’s current Faculty Development Institute.

In 2000, the organization also formed a task force to report on the issue of the master’s degree in PA education. This report was to provide recommendations with regard to the entry-level degree for PAs. In investigating the factors affected by the increasing standardization of all PA programs to the master’s degree, the task force included analysis on how such standardization would affect student diversity. The CECD and other members of the Association were concerned that an entry-level master’s degree would reverse the trend of increasing diversity in PA programs. Other members felt the master’s degree would not affect diversity. While the report found that “various entry points into the profession provides the opportunity for a greater number of individuals from diverse and disadvantaged backgrounds to enter the profession,” it was unable to show a causal relationship between degree and access to the PA profession. The report recommended that the Association recognize that PA education is graduate-level work but that individual institutions may choose to offer degrees other than the master’s degree. Today, most of the predominately minority programs are non-master’s degree programs.

The CECD was the catalyst for several of PAEA’s diversity initiatives. In 2003, the committee initiated the inclusion of diversity language into the Association’s mission statement by sponsoring a resolution calling for this action. The committee felt that a mission statement promoting diversity would demonstrate an organizational commitment to diversity. The following year the new (current) mission statement with a commitment to “promote diversity in all aspects of physician assistant education”17 was adopted by the Association.

By the beginning of the millennium, various accrediting bodies for the education of health professions programs began to address diversity enrollment of students and recruitment of diverse faculty, and well as cultural competency curriculum.18 In 2003, the Liaison Committee on Medical Education adopted multiple standards in these specific areas.19 In 2004, the CECD sponsored a controversial resolution calling for the proposed 3rd edition of the ARC-PA Standards to include specific standards for PA diversity curriculum and the retention and recruitment of minority students and faculty. An amended resolution passed and the Association made a formal request to have diversity reflected in the ARC-PA Standards. The new Standards, which took effect in September 2006, contain only two vague standards relating to diversity: B1.09, which states that “The program must prepare students to provide med-
ical care to patients from diverse populations”; and B6.01a: “The program must provide instruction in: cultural issues and their impact on health policy.”20 (See Figure 2.) They did not include the suggested revisions that had been developed by the CECD and voted on by the APAP member programs. Should terminology such as that proposed by the CECD ever be included in the ARC-PA standards, PA education will be one of the last health care professions to include it.

The CECD and its predecessors have made several contributions to PAEA and PA education. The committee has provided numerous diversity-related presentations at the Association’s meetings. In addition to the previously mentioned Minority Issues Faculty Development Workshop, there have been sessions on specific cultural competency curricula, Institute of Medicine (IOM) reports on health disparities and health care workforce diversity, and the results of committee surveys on PA program diversity experiences. In 2005, the CECD presented its model of core cultural competencies for PA education to provide programs with guidance for developing cultural competency curriculum. The committee has also helped produce some of the minority leadership of the Association, including board members Brenda Jasper, Ron Garcia, and Dawn Morton-Rias. Both Garcia and Morton-Rias became president.

FUTURE DIRECTIONS
To adequately prepare students to provide effective health care will require PA educators to continue in their efforts to diversify our student bodies and integrate cultural competency into our curricula. Although many programs have demonstrated successful ways to recruit and retain underrepresented minority students and provide the needed skills for working with increasingly diverse patients,21,22 several barriers remain. If PA programs and graduates are to meet the health care needs of the nation, we will need both resources and support from our institutions and accrediting bodies. Following is a discussion of trends in health professions that may provide future directions for increasing diversity in PA education.

Data Collection
In the future, there will be an increasing demand for governmental and higher education institutions to be accountable for student outcomes.23 This will require more consistent and complete data collection with regard to the demographics of our applicants, enrolled students, and graduates. Specifically, the outcomes of minority applicant-to-enrollment rates, graduation and attrition rates, and the communities and practices in which graduates are employed in will be analyzed as part of a focus on addressing health disparities.

Problems with current data collected about PA student demographics include disagreement about definitions, inconsistent racial classifications, and low response rates, resulting in missing or unreported data. The most recent PAEA Annual Report indicates a response rate of 83.6%.7 While statistically such a response rate may be sufficient to determine trends such as for student enrollment and graduation for PA education, minority representation in PA education is clustered in a handful of programs, so that missing data from even a couple of these can skew the overall data greatly. All organizations collecting data about PA education should use a classifica-

### Table 1. Excerpts from Standards for Accreditation of Medical Education and Physician Assistant Education Programs

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<tr>
<th>Functions and Structure of a Medical School: Standard for Accreditation of Medical Education Programs Leading to the MD Degree</th>
<th>Accreditation Standards for Physician Assistant Education 3rd Edition</th>
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<tr>
<td>Each medical school should have policies and practices ensuring the gender, racial, cultural, and economic diversity of its students. 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 that it serves. 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. 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.</td>
<td>B1.09. The program must prepare students to provide medical care to patients from diverse populations B6.01a. The program must provide instruction in: the impact of socioeconomic issues affecting health care.</td>
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Curriculum

Curriculum that focuses on improving PA students’ understanding of and communication in racially and ethnically diverse communities has evolved since the profession’s inception. The first methodology for development of diversity curriculum included incorporating information that focused on or listed some of the racial and ethnic group differences that could affect health. The next phase involved curriculum with prescriptive approaches to practicing with specific racial and ethnic groups. It became clear that knowledge about ways in which patients differ from providers was not enough to improve quality of care for diverse populations — curriculum designed to address attitudes about these differences would need to be implemented. In some PA programs, the coursework evolved from one or two modules to several sessions or even courses that focused on knowledge and attitudes relating to cultural competency. Cultural competency curriculum has now evolved to address the knowledge, attitudes, and skills to care for patients from racial, ethnic, and cultural backgrounds that are different from that of the PA. It is felt that the cultural competency curriculum content is most effective when implemented throughout the curriculum, as opposed to added on as a separate course or lecture.

DIVERSITY IN POLICY

Prior to the Supreme Court decision about the University of Michigan admissions case, several organizations began to discuss ways in which to continue increasing the diversity in health professions, should race and ethnicity no longer be able to be considered in admissions decisions. In 2004, the IOM issued a report addressing the importance of diversity in health care policy, particularly accreditation standards for hospitals and health professional schools. Although the addition of new accreditation standards for PA programs is often controversial, several health professions have recently adopted such standards in an effort to address diversity issues at a policy level. Accrediting bodies for nursing, dentistry, psychology, and medicine have adopted standards that address diversity of students and faculty as well as cultural competency in the curriculum.

As mentioned earlier, in the fall of 2004, the PAEA CECD drafted a resolution recommending adoption of accreditation standards addressing diversity (Figure 2). While recognizing that prescriptive standards are often ineffective, the CECD proposed adopting language similar to the Liaison Committee on Medical Education standards that state programs should demonstrate effort by having plans in place for increasing the diversity of faculty and students. This language allows for each program’s efforts to parallel the mission of its respective institution and allow for individual program focus. As PA educators consider the inclusion of such standards for accreditation, discussion should include the effectiveness of current standards in addressing issues of diversity and how proposed standards can be evaluated in the future to determine whether they are achieving their intended aim.

CONCLUSION

The history of diversity in PA education reflects the profession’s ability to address the health care needs of a growing nation. In order to successfully continue to meet these needs in the future, PA education must continue to incorporate and address issues of diversity that affect health care and educational outcomes for which we will be increasingly responsible. Clear and consistent data with regard to those we educate and graduate, supported by strong policy, will help ensure future resources to address disparities within our programs. Continued improvement of our curriculum to teach social and cultural competency will improve the quality of health care our graduates provide by teaching them skills needed for a diverse patient population. With strong leadership and diligent adherence to principles that have shaped our profession to this point, the future for PA faculty, students and patients is promising.
REFERENCES