Lack of Racial and Ethnic Diversity Among Addiction Physicians

J Gen Intern Med
DOI: 10.1007/s11606-022-07405-8
© The Author(s) under exclusive licence to Society of General Internal Medicine 2022

INTRODUCTION

Compared to white individuals, Black, Indigenous, and Latinx individuals have decreased access to addiction care, lower rates of addiction treatment, and higher rates of incarceration, non-fatal overdose, and death.[1] Racial/ethnic concordance between patients and clinicians has been associated with improved communication and patient satisfaction with care and may lead to improved addiction outcomes including medication adherence and treatment retention.[1,2] To understand addiction physician diversity, we evaluated the physician race/ethnicity by gender, career stage, and practice characteristics using American Society of Addiction Medicine (ASAM) membership data.

METHODS

ASAM provided de-identified 2021 membership data, including race/ethnicity, gender (male/female), career stage, clinical specialty, addiction certification, and practice location (state). We included active US physicians, classifying specialties into three categories (addiction specialty, primary care, and other) and practice location into seven regions (Table 1). We compared gender, career stage, and practice characteristics by race/ethnicity and ASAM member physicians certified by one of the addiction boards to those not certified, using chi-square tests (Stata version 14.2; College Station, TX: StataCorp LP).

RESULTS

Nearly 1 in 4 ASAM members did not provide race/ethnicity data. Black, Indigenous, and Latinx physicians comprised 12% of ASAM members who reported their race/ethnicity (*N*=276 of 2,251 members). While two-thirds of physicians overall identify as men, 75% of Indigenous physicians and 45% of Black physicians identify as women; 4% did not answer the binary question.

Race/ethnicity was similar across career stages (12% residents/fellows, 14% early career, and 13% regular members reported race/ethnicity as Black, Indigenous, or Latinx). Racial/ethnic diversity varied by region; more Black and Latinx physicians practice in the Southern region. Asian, Black, and Indigenous physicians were less likely to have addiction board certification compared to white physicians.

DISCUSSION

While Black, Indigenous, and Latinx individuals comprise 33% of the US population, they represent 12% of ASAM physicians who reported race/ethnicity. Our findings support a prior study which found that Black, Indigenous, and Latinx individuals represent less than 14% of addiction fellows and practicing addiction psychiatrists.

The lack of racial/ethnic diversity in addiction medicine reflects the lack of diversity in medicine. Black, Indigenous, and Latinx physicians comprise only 11.1% of US physicians.[3] To diversify the physician workforce, we need widespread policy changes, including increased funding for medical schools in underserved communities, financial aid for students without access to generational wealth, more comprehensive loan repayment policies, and programs to expose students to medical careers.

Diversifying the workforce to reflect our country's population is critical. Underrepresented in medicine (UIM) physicians, who have been historically excluded from medical careers, are more likely to care for underserved populations.[4] Furthermore, racial/ethnic concordant physician-patient dyads are associated with better health outcomes.[1,2] The dearth of UIM addiction physicians is especially urgent given our current overdose epidemic, with the highest rates of death among Black and Indigenous individuals and increasing rates of overdoses among Latinx individuals.[5,6] Low percentages of UIM physicians across career stages suggest that this lack of representation is unlikely to change without concerted efforts to remove ingrained systemic barriers to pursuing medical training.

Our study had several limitations. Our data comes from a single professional society. Notwithstanding, ASAM is the largest addiction medicine society in the USA and includes physicians in specialties other than psychiatry. Our findings

Prior presentations: *None.*
Received October 4, 2021
Accepted January 5, 2022

Published online: 31 January 2022

Table 1 Demographic Characteristics of Physician Members of the American Society of Addiction Medicine in 2021 (*N*= 2933)

	Total *N*= 2933	Asian *N*= 205 (7%)	Black *N*= 149 (5%)	Indigenous *N*= 16 (1%)	Latinx *N*= 111 (4%)	White *N*= 1676 (57%)	Other *N*= 94 (3%)	Missing *N*= 682 (23%)	
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	*p*-value
Gender:									*p*< 0.001
Women	865 (30)	45 (22)	67 (45)	12 (75)	32 (29)	482 (29)	28 (30)	199 (29)	
Men	1954 (67)	159 (78)	82 (55)	4 (25)	79 (71)	1185 (71)	66 (70)	379 (56)	
No answer	115 (4)	1 (1)	0	0	0	9 (1)	0	105 (15)	
Career stage*:									*p*< 0.001
-Residents and Fellows	1444 (49)	94 (46)	76 (51)	6 (38)	51 (46)	887 (53)	38 (40)	292 (43)	
-Early career	315 (11)	38 (19)	14 (9)	2 (13)	15 (14)	134 (8)	12 (13)	100 (15)	
-Regular	1174 (40)	73 (36)	59 (40)	8 (50)	45 (41)	655 (39)	44 (47)	290 (43)	
Primary specialty†:									*p*<0.001
-Addiction Specialty	225 (8)	8 (4)	9 (6)	0 (0)	9 (8)	162 (10)	0	37 (5)	
-Primary Care	708 (24)	34 (17)	39 (26)	8 (50)	23 (21)	466 (28)	21 (22)	117 (17)	
-Other	1231 (42)	104 (51)	60 (40)	7 (44)	52 (47)	706 (42)	46 (47)	256 (38)	
-Not listed	768 (26)	59 (29)	41 (28)	1 (6)	27 (24)	342 (20)	27 (29)	271 (40)	
Practice region‡:									*p*< 0.001
-California-Hawaii	369 (13)	30 (15)	13 (9)	2 (13)	18 (16)	179 (11)	20 (21)	107 (16)	
-Mid-Atlantic	461 (16)	31 (15)	26 (17)	1 (6)	16 (14)	256 (15)	18 (19)	113 (17)	
-Midwest	584 (20)	45 (22)	34 (22)	6 (38)	9 (8)	333 (20)	17 (18)	141 (21)	
- Mountain West	199 (7)	8 (4)	5 (3)	0	14 (13)	127 (8)	4 (4)	41 (6)	
-New England	211 (7)	7 (3)	5 (3)	1 (6)	4 (4)	137 (8)	3 (3)	54 (8)	
-Northwest	149 (5)	6 (3)	1 (<1)	3 (19)	3 (3)	90 (5)	6 (6)	40 (6)	
- Southern	960 (33)	78 (38)	66 (43)	3 (19)	47 (42)	554 (33)	26 (28)	186 (27)	
Addiction certified§	1794 (61)	119 (58)	90 (60)	9 (56)	72 (65)	1068 (64)	54 (57)	382 (56)	*p*= 0.02

Percentages may not add up to 100% due to rounding.
**Career stage is defined by the American Society of Addiction Medicine. "Residents and Fellows" include interns, residents, and fellows in any medical specialty. "Early career" are those physicians in their first 2 years after completing an accredited residency or fellowship or in their first 2 years of practicing Addiction Medicine as a significant portion of their practice. "Regular members" must be licensed to practice allopathic or osteopathic medicine in the USA.*
†Primary specialty is categorized as follows, from physician self-reported specialty: Addiction Specialty (includes specialties in Addiction Medicine and Addiction Psychiatry), Primary Care (includes specialties in Primary Care and Family Medicine or Practice), and Other (Internal Medicine, Gastroenterology, Forensics, Hospitalist, anesthesiologist, Emergency Medicine, Other).
‡Practice region was determined according to Society of General Internal Medicine regional classification for states. California-Hawaii includes California and Hawaii. Mid-Atlantic includes Delaware, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, and Washington, DC. Midwest includes Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, and Wisconsin. Mountain West includes Arizona, Colorado, Nevada, New Mexico, Utah, and Wyoming. New England includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Northwest includes Alaska, Idaho, Montana, Oregon, and Washington. Southern includes Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia.
§Addiction certified includes members certified by one or more of the certifying addiction medicine bodies: the American Board of Preventive Medicine (ABPM) the American Board of Psychiatry and Neurology (ABPN), the American Board of Addiction Medicine (ABAM).

are also limited by the 23% of individuals who did not report race/ethnicity; it is unknown whether UIM physicians are more, less, or equally likely to report race/ethnicity than white physicians. To develop informed efforts to diversify the addiction physician workforce and track changes, we need accurate numbers. Further work to improve race/ethnicity reporting among professional societies and board certification organizations is key to characterizing the diversity of the current addiction workforce, identifying gaps, and measuring changes over time.

Similarly, we need to accurately measure gender identity with gender affirming options and take measures to improve gender representation. Organizations must also characterize other measures of diversity, including the non-English language abilities of physicians. Finally, we cannot assess whether unmeasured factors differentially affect the likelihood of UIM physicians joining ASAM compared to white physicians.

To ensure a future with a racially/ethnically diverse group of addiction physicians, addiction professional societies, fellowships, and residency programs need to invest more resources to recruit racial/ethnically diverse trainees and implement and evaluate workforce diversity interventions.

Acknowledgements: *We thank Dr. Brian Hurley, MD, MBA, President-Elect of the American Society of Addiction Medicine (ASAM), and Vernon Hemphill Sr, Director of Membership and Chapter Relations at ASAM, for providing the data for this study. We thank Matthew Perrotta, MPH, for assisting with data analysis.*

Maria E. Garcia, MD, MPH, MAS[1]
Janet Coffman, MA, MPP, PhD[2]
Ayana Jordan, MD, PhD[3]
Marlene Martin, MD[4,5]

[1]Division of General Internal Medicine, Department of Medicine, University of California, San Francisco, San Francisco, CA, USA
[2]Philip R. Lee Institute of Health Policy Studies, University of California, San Francisco, San Francisco, CA, USA
[3]Department of Psychiatry, New York University Grossman School of Medicine, New York, NY, USA
[4]Division of Hospital Medicine, San Francisco General Hospital, San Francisco, CA, USA
[5]Department of Medicine, University of California, San Francisco, San Francisco, CA, USA

Corresponding Author: *Maria E. Garcia, MD, MPH, MAS; Division of General Internal Medicine, Department of Medicine, University of California, San Francisco, San Francisco, CA, USA (e-mail: maria.garcia@ucsf.edu).*

Funding *Dr. Garcia received support through an NIMHD K23MD015115; the content does not necessarily represent the official views of the NIMHD or the NIH. Dr. Jordan is supported by the National Institutes of Health (NIAAA 5R01AA028778-02) and grants from Yale University.*

Declarations:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

REFERENCES

1. Guerrero EG, Marsh JC, Duan L, Oh C, Perron B, Lee B. Disparities in completion of substance abuse treatment between and within racial and ethnic groups. *Health Serv Res.* 2013;48(4):1450-1467. https://doi.org/10.1111/1475-6773.12031
2. Shen MJ, Peterson EB, Costas-Muñiz R, et al. The effects of race and racial concordance on patient-physician communication: a systematic review of the literature. *J Racial Ethn Health Disparities.* 2018;5(1):117-140. https://doi.org/10.1007/s40615-017-0350-4
3. Figure 18. Percentage of all active physicians by race/ethnicity, 2018. AAMC. Accessed December 22, 2021. https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018
4. Xierali IM, Nivet MA. The racial and ethnic composition and distribution of primary care physicians. *J Health Care Poor Underserved.* 2018;29(1):556-570. doi:https://doi.org/10.1353/hpu.2018.0036
5. The opioid crisis and the Black/African American population: an urgent issue. :30.
6. The opioid crisis and the Hispanic/Latino population: an urgent issue. :35.

Publisher's Note: *Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.*