Student Enrollment, Practitioner Diversity, and Patient Outcomes: Another Challenge for Educators

For the past several years, respiratory care education has been a source of heated debate resulting from publication of the "2015 and Beyond" recommendations[1-3] and more recently by the general discussion of the decision to withdraw Policy 13 by the Tripartite.[4] When these types of serious discussions take place in a healthy manner and include all stakeholders, the result can be moderate corrections in the direction of the profession, and ultimately, these peer-driven critiques ensure our profession's place in the future of the health-care delivery system.

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Today's workforce and, more importantly, today's patients do not represent the workforce and patient population that will be present a decade from now. Additionally, evolution of practice throughout the workforce is a lengthy process. One publication suggests that the amount of time it takes published research to change practice is no less than 17 years.[5] Because of this, employers and monitors of health-care delivery need to speculate far ahead to provide the best care available.

In this issue of RESPIRATORY CARE, Becker and Nguyen[6] identify another issue ripe for debate among all health-care education programs. They explore the demographics and ethnic diversity accompanying entry-level associate and baccalaureate education. What they found is a situation typical across all health-care provider fields of study and professional practice. There are relatively few minority health-care students or practicing providers. Unfortunately, this problem is not new and is considered to have always been the case.[7,8] Interestingly, Becker and Nguyen found comparable demographic patterns in current college enrollment at both the associate and baccalaureate degree levels. This suggests that changes to entry-level requirements as recommended in the "2015 and Beyond" documents would not improve the ethnic disparity that currently exists. At each level of education, there are limited numbers of minority students whose demographics do not mirror the population demographics of the United States. Correspondingly, members of minority populations are more likely to receive a lower quality of care, experience higher rates of illness and disability, and die at a younger age than whites.[8,9] A specific example of this is the higher rate of asthma and asthma-related morbidity and mortality in African-Americans in the United States compared with whites.[10] One study found that closing the black-white mortality gap would eliminate a startling 83,000 excess deaths per year among African-Americans.[11]

A number of national and international organizations, including the Institute of Medicine and Physicians for Human Rights, believe that a diverse workforce that mirrors the nation's racial and ethnic patterns is a key to achieving excellence in health care.[12] The rationale for increased diversity in the health-care workforce is that it will improve the overall health of the nation by creating a system that has a better grasp on ethnic, cultural, and language barriers to quality health care. Reaching toward a more diverse population of health-care providers will ultimately result in a generation of respiratory therapists better prepared to provide culturally sensitive and population-directed patient care.[13] This is congruent with the longstanding goal of the United States government to assemble a health-care workforce reflecting the United States population's diversity.[14]

Becker and Nguyen[6] should be applauded for bringing the issue of racial and ethnic disparities in respiratory care to the forefront. While we are debating the issue of entry-level requirements for graduate respiratory therapists, finding strategies to reduce racial and ethnic disparities as a way to improve the respiratory health of our patients should also be added to the list of goals for the future of respiratory care education and workforce development.

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