Mission Drift: Are Medical School Admissions Committees Missing the Mark on Diversity?

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Abstract
Diversity initiatives in U.S. medical education, following the passage of the Civil Rights Act of 1964, were geared towards increasing the representation of African Americans—blacks born in the United States whose ancestors suffered under slavery and Jim Crow laws. Over time, blacks and, subsequently, underrepresented groups in medicine (URMs), became a proxy for African Americans, Puerto Ricans, Mexican Americans, and Native Americans, thus obscuring efforts to identify and recruit specifically African Americans. Moreover, demographic shifts resulting from recent immigration of black people from Africa and the Caribbean have both expanded the definition of “African American medical students” and shifted the emphasis from those with a history of suffering under U.S. oppression and poverty to anyone who meets a black phenotype. Increasingly, research indicates that African American patients fare better when their physicians share similar historical and social experiences. While all people of color risk discrimination based on their skin color, not all have the lived experience of U.S.-based, systematic, multigenerational discrimination shared by African Americans. In the high-stakes effort to increase URM representation in medical school classes, admissions committees may fail to look beyond the surface of phenotype, thus missing the original intent of diversity initiatives while simultaneously conflating all people of color, disregarding their divergent historical and social experiences. In this Perspective, the authors contend that medical school admissions committees must show greater discernment in their holistic reviews of black applicants if historical wrongs and continued underrepresentation of African Americans in medicine are to be redressed.
Over time, the original purpose of efforts to increase diversity in U.S. medical education has evolved, such that the initial efforts to redress the historical wrongs endured by African Americans—blacks born in the United States whose ancestors suffered under slavery and Jim Crow laws—have eroded. In this Perspective, the authors argue that diversity efforts should go beyond phenotype and again account for historical and cultural background not only to increase the representation of African Americans in medical education and medicine, but also to help bridge the gap between the health outcomes of African Americans and those of white Americans.

The History of Diversity Initiatives in Medicine

When the Civil Rights Act passed in 1964, approximately 2% of medical students were black (previously referred to as Negroes), and 76% of black students were enrolled at historically black medical schools—Howard and Meharry.1 (Morehouse School of Medicine and Charles R. Drew University of Medicine and Science were not established until later.) The number of Latino and Native American medical students was substantially lower, prompting the Association of American Medical Colleges (AAMC) to use blacks as an “adequate proxy” for all minority groups. The AAMC designated blacks, Mexican Americans, mainland Puerto Ricans, and American Indians as underrepresented minorities in medicine (URM) in 1970.2 Propelled by societal changes, affirmative action initiatives, and federal financial aid programs for minorities in late 1960s, the number of URM medical students expanded to over 8% by 1971.3 This proportion of URM medical students remained relatively flat in the 2 following decades despite increased percentages of people who could be categorized as URM in the general U.S. population.4 Thus, in 1990, the AAMC launched Project 3000 by 2000 with the goal of enrolling 3,000 URM students annually in U.S. medical schools accredited by the Liaison Committee on Medical Education (LCME) by the year 2000.5
Subsequently, the number of URM students entering medical school increased from under 1,500 in 1990 to over 2,000 in 1994. This surge peaked in 1996, however, as the 1990s saw anti-affirmative action ballot initiatives and lower-court decisions that prohibit institutions of higher education in several states, including Texas and California, from considering applicants’ race or ethnicity in admissions decisions.\textsuperscript{3,4}

The effects of this slowed momentum persisted despite 2003 and 2016 U.S. Supreme Court rulings in favor of considering race to achieve diversity in higher education. In 2011, the notion of Diversity 3.0, adapted from an IBM [International Business Machines] concept, called for medical education diversity efforts to shift from just improving minority representation and alleviating the barriers faced by marginalized populations to, instead, developing a culture of inclusion that fully appreciates and honors differences of perspective. Marc Nivet, the author of the Commentary (which was published in this journal), cautions medical schools and hospitals not to abandon programs that have proven records of eliminating inequalities and injustices.\textsuperscript{6}

Furthermore, the U.S. Supreme Court case of Adarand Constructors, Inc. v Peña\textsuperscript{7} held that racial considerations should serve and further government interest, and in the U.S. Supreme Court case of Regents of the University of California v. Bakke,\textsuperscript{8} the usage of race in a state university’s admission policy was approved for the purpose of promoting diversity. Still, institutions remained regrettably cautious about applying this rationale for promoting equity to their admissions policies and procedures, and this reluctance limited the overall outcomes of many medical education diversity initiatives nationwide.
Black Subgroups

Another important factor influencing diversity and diversity initiatives in U.S. medical education is the reality that the group considered black is diverse in and of itself. To illustrate, the term African includes continental Africans as well as diasporic Africans (those living in various non-African countries around the world).

For the purpose of this Perspective, we define African Americans as blacks born in the United States who are the descendants of those who have suffered the ills of U.S. slavery and subsequent Jim Crow laws. Until the late twentieth century, nearly all black Americans were African Americans, as perhaps the social climate in the United States up to that point was not conducive to black immigration. More recently, however, according to the Pew Research Center, the total number of foreign-born blacks in the United States has increased from 816,000 in 1980 to approximately 4.2 million in 2016.9 In fact, about 9% of the approximately 40 million non-Hispanic blacks in the United States are foreign-born. Although this increase is in part the result of African migration, about half of all foreign-born blacks currently living in the United States are from the Caribbean.9

These trends are not reflective of the composition of black students in U.S. medical schools. Many of the medical students who identify as “Black or African American” are foreign-born blacks living in the United States, or they are second-generation children of those who immigrated to the United States. In fact, the majority (52%) of black applicants to U.S. LCME-accredited medical schools identify with a black subgroup other than African American. In 2015, 19% of black medical school applicants identified as “African,” 10% as “Afro-Caribbean,” 14% as “Multiple Black or African American,” 8% as “Black or African American Without Subcategories,” and 1% as “Other Black or African American.” The overall rate of acceptance
was about 33% for all black applicants, including the subset of those identifying solely as African American.\textsuperscript{10} Thus, while African Americans constitute the majority of black Americans, they make up only 48% of black students in U.S. LCME-accredited medical schools and remain significantly underrepresented in medicine despite overall increases in the numbers of black students.

The numbers for African American males in medicine are even more disproportionate. More black females have graduated from U.S. medical schools than black males since 1989. The gender gap among black graduates has been as high as 37.2% (in 2007), and was at 30.6% in 2015.\textsuperscript{10} Blacks are currently the only identified racial ethnic group in the United States for which the number of female full-time U.S. medical school faculty is greater than the number of male full-time U.S. medical school faculty.\textsuperscript{10} Of the 4,087 black applicants to U.S. medical schools in 2015, 1,535 were male, and only 698 identified as specifically African American males.\textsuperscript{10} Of the 556 black males who ultimately matriculated to medical school, only 271 identified as African American.\textsuperscript{10} Conversely, in 1978, 1,410 black males applied to U.S. medical schools and 542 matriculated, indicating that not much has changed in the last 40 years other than the racial subgroup composition of black applicants.\textsuperscript{11}

**The Current State of Blacks in U.S. Medicine**

African Americans continue to lag behind whites in measures of educational achievement, income, and wealth. While black and white girls from families with comparable incomes tend to attain similar individual incomes as adults, black boys are more likely than white boys from similar economic backgrounds to become poor than to stay wealthy on their own as adults.\textsuperscript{12} A study done by researchers at Harvard, Stanford, and the U.S. Census Bureau explored this disparity in detail and found that growing up in families with similar incomes, family structure,
parental education, and accumulated wealth did not insulate black males from earning less than white males as adults. In fact, black males from high-earning parents have an equal chance of being incarcerated as adults as white males from low-income families.\(^\text{12}\) In contrast to the findings for black males, Hispanics generally neutralize the income gap between themselves and whites after a couple of generations; Asian Americans tend to earn more than whites starting from similar circumstances; and Native Americans have an income gap comparable to, but not quite as large as, blacks.\(^\text{12}\) Even though African immigrants may have experienced poverty in their home country, or upon arrival in the United States—or both—most African immigrants are, notably, from middle and upper classes in their home countries and most have rates of college education that exceeds white and Asian Americans.\(^\text{13}\) Thus, we reasonably infer that the data on educational achievement, income, and wealth would be worse for African Americans if completely isolated from other black subgroups.

Once thought to be primarily related to economic status, race has become a greater predictor of SAT performance than parental education and family income.\(^\text{14}\) The gap between ACT and SAT scores of black and white students remains problematic. Blacks continue to lag behind all other minority groups on both exams.\(^\text{15,16}\) Similar trends occur on graduate school standardized examinations, and the Medical College Admissions Test (MCAT) is no different. Black applicants and matriculants to U.S. LCME-accredited medical schools generally score lower than every recognized race/ethnicity.\(^\text{17}\) Notably, the reason blacks score lower on standardized exams has yet to be clearly defined (and is also beyond the scope of this Perspective). The point is that slavery, Jim Crow, and institutionalized racism have had lasting effects on African American educational attainment that clearly outweigh economics.
Not surprisingly, black applicants have lower medical school acceptance rates than those enjoyed by members of other racial and ethnic groups, a phenomenon that contributes directly to the small pool of black health care providers. Currently, just 3% of U.S. medical school full-time faculty are black, and approximately 6% of graduates from U.S. LCME-accredited medical school are black.¹⁰

**Why Diversity in Health Care and Medical Education Matters**

These low numbers of physicians and physicians-in-training likely contribute to the health disparities between African Americans and white Americans. According to the Center for Disease Control and Prevention (CDC), the life expectancy for African Americans (74.8 years) lags behind that of white Americans, (78.5 years), and the life expectancy of African American males is even lower (71.5 years).¹⁸ In the United States, the age-adjusted death rate of non-Hispanic blacks is higher than that of non-Hispanic whites for 9 of the 15 leading causes of death, including heart disease, malignant neoplasms (cancer), cerebrovascular diseases (stroke), diabetes, kidney disease, and hypertension (List 1).¹⁹

Although prevention and management play a major role in the manifestation of many of these conditions, myriad social and economic determinants, as well as some genetic variations, contribute to these health disparities and inequities—particularly among African Americans. Importantly, in the last several decades, the underrepresentation of minority health care providers has garnered increased attention as a contributor to health disparities. For example, the results of a recent study in Oakland, California, showed that black men were more likely to engage in preventive services recommended by black physicians.²⁰ The research estimated that related changes in behavior could translate into a 19% reduction in the cardiovascular mortality gap between white and black men.²⁰ Their findings align with those of LaVeist and colleagues, which
indicated that provider-patient race concordance correlates to greater use of services, improved compliance, and higher patient satisfaction.\textsuperscript{21,22}

Very little research has examined the differences in the health of those identifying as members of various black American subgroups. In 2011 Griffin and colleagues found that African Americans, U.S.-born Caribbean blacks, and Afro-Caribbean immigrants to the United States had different self-ratings of health and varying self-reported rates of chronic disease.\textsuperscript{23} Several years later a study in the \textit{Journal of Immigrant and Minority Health} reported differences in cancer screening amongst African Americans and Afro-Caribbean immigrants.\textsuperscript{24} Whether these differences in screening translate into differences in disease morbidity and mortality is unclear.

**Where Do We Go From Here?**

Given the history of initiatives to increase diversity in U.S. medical schools, the lack of progress, and the pressing need to improve the health outcomes of black Americans, we ask, Are medical school admissions committees missing the mark on diversity? The answer, as it pertains to African Americans, is a definitive \textit{Yes}. African Americans continue to experience considerable health disparities and inequities, which correlate to a lower life expectancy. Despite a growing body of evidence illustrating the public health and patient care benefits of expanding the number of African Americans in the physician workforce, and despite decades of national decrees and initiatives, African Americans, particularly African American males, remain significantly underrepresented in U.S. medical schools. Additionally, the black students that are matriculating to U.S. LCME-accredited medical schools are increasingly part of subgroups that are not the descendants of those who have suffered the ills of U.S. slavery and subsequent Jim Crow laws, the population originally intended to benefit from medical school diversity initiatives.
Ameliorating the paucity of African Americans in medical education is a challenging endeavor since race, ethnicity, and the concepts of diversity have become increasingly complex in the United States. The foreign-born members of different subgroups of blacks living in the United States may identify with African Americans socially and experience many of the same ills of racial discrimination and inequity, but they do not share the same history. That is, based on historical origins, there are differences in attitudes, culture, and values between black American immigrants and African Americans, and these differences may, in turn, lead to differences in the direction and purpose of their careers as health care providers. Therefore, conflating all black applicants is overly simplistic and inaccurate.13 Diversity initiatives, such as Diversity 3.0, must remain a focus and goal of U.S. medical schools. While creating diverse, rich educational environments is certainly valuable, Diversity 1.0 and 2.0 methodologies remain important and relevant. These methodologies have provided the foundational framework for medical school diversity strategies across the United States, and they must continue to be funded, emphasized, and embraced. Identity-oriented initiatives that are designed to increase specific compositional diversity as means to improving representation and righting previous societal wrongs continue to have a place in medical education and must be reenergized.6 Any notion that these strategies challenge the pursuit of institutional excellence needs to be abandoned. Increasingly medical school admissions committees can expect applicants of color whose personal stories weave together both American and African roots—as well as Hispanic, Native American, and white identities. Committee members must seek to foster admissions practices that allow for the consideration and contextualization of the genealogical heritage of URM students, particularly black students, as part of a holistic review of applications. By its very
nature, holistic review must parse the subtleties and distinctions of each individual candidate’s application, attending specifically to the social context and ancestral legacy—whether in the United States or abroad—that informs that candidate’s history. Admissions committees must also continue to explore the complexities of national, racial, and cultural identity, particularly noting the corrosive effects of financial and social deprivation. A renewed investment in programs and activities that reach into the geographic and social communities of African Americans to encourage, inspire, and prepare students to compete in the mainstream is essential. When admissions processes are culturally safe for African Americans, then the classroom-to-exam-room pipeline will truly open, allowing African Americans to advance a deep and broad cadre of physicians.
References


List 1
The 15 Top Leading Causes of Death of Adults (of Any Race/Ethnicity) in the United States, 2016

Diseases of the heart (heart disease)
Malignant neoplasms (cancer)
Accidents (unintentional injuries)
Chronic lower respiratory diseases
Cerebrovascular diseases (stroke)
Alzheimer’s disease
Diabetes mellitus (diabetes)
Influenza and pneumonia
Nephritis, nephrotic syndrome, and nephrosis (kidney disease)
Intentional self-harm (suicide)
Septicemia (sepsis)
Chronic liver disease and cirrhosis
Essential hypertension and hypertensive renal disease (hypertension)
Parkinson’s disease
Pneumonitis due to solids and liquids (rather than infection)


bHigher age-adjusted death rate amongst non-Hispanic blacks than non-Hispanic whites.