

Minorities entered medical schools in record numbers in the early 1990s, but recent court decisions have called into question using race as an admission criterion. With minority enrollment down in the last several years, diversity advocates question the quality of care minority patients will receive in the future.

What Color

SHOULD MEDICINE BE?

To begin his literary classic *A Tale of Two Cities*, Charles Dickens wrote “it was the best of times, it was the worst of times” to describe life in 18th-century Europe. More than 200 years later, those same words can be used to describe the state of minority admissions in U.S. medical schools over the past decade.

The 1990s started with a bang. Minority admissions rose every year, reaching record highs by mid decade. But the tide quickly turned in 1996 after a series of anti-affirmative-action efforts swept the nation. By the decade’s close, several lawsuits targeting university admission policies coincided with a rapid fall in the enrollment of minority medical school students.

The decline was both swift and dramatic, wiping out nearly all the gains achieved during the decade’s early years.

At their peak in 1995, under-represented minority students comprised 12.4 percent of U.S. medical schools’ admissions. Just five years later, the matriculating population of Mexican Americans, mainland Puerto Ricans, Native Americans, and African Americans—the four groups considered under-represented U.S. minorities—dropped to 10.6 percent.

DIVERSITY IN MEDICINE

Continued from previous page



ILLUSTRATION BY SUSAN LE VAN

Medical School Enrollment

By race				Racial composition compared with overall 2000 population	MEDICAL SCHOOL ENROLLMENT	U.S. POPULATION
Under-represented minorities are in bold	1991	1995	2000			
Black	4,334	5,337	4,933	Black	7.4	12.3
Native American	301	501	537	Native American	0.8	0.9
Mexican American	1,205	1,769	1,674	Mexican American	2.5	7.3
Puerto Rican—Mainland	485	455	465	Puerto Rican—Mainland	0.7	} 1.2
Puerto Rican—Commonwealth	817	878	766	Puerto Rican—Commonwealth	1.1	
Asian/Pacific Islander	9,438	11,352	13,200	Asian/Pacific Islander	19.8	3.7
Other Hispanic	1,138	1,247	1,317	Other Hispanic	2.0	4.0
White	47,094	44,594	42,100	White (Not Hispanic)	63.4	69.1
Other	132	286	727	Other	1.0	5.5
Foreign	658	551	649	Foreign	0.9	0
Total	65,602	66,970	66,390			

Sources: Association of American Medical Colleges Student Records System and U.S. Census Bureau, Census 2000

Diversity advocates view this reversal as troubling as the country becomes increasingly multi-cultural. Estimates project that African-Americans, Hispanics, and Native Americans will make up 36 percent of the U.S. population by 2035. Advocates believe training a physician work force that does not even come close to that ethnic representation sets a large portion of the country up to be medically misunderstood.

Minority groups all have unique aspects to their

culture. Physicians raised in these cultures not only better understand minority patients, but their very presence in the medical work force raises the awareness of their non-minority colleagues about how best to treat them, says Lois Colburn, the assistant vice president for minority programs at the American Association of Medical Colleges.

“As this country becomes increasingly diverse, it is important that our health-care work force mirror the popu-

DIVERSITY IN MEDICINE

Continued from previous page

lation to provide the best possible care to everyone," Colburn says. "Medical schools know that. This is an issue that they will have to continue to put time, commitment, and resources into."

The old way

Since the civil rights movement of the 1960s, many schools have attempted to gain diversity through a two-tiered admissions system. Minority applicants are given "points" just for being African-American, Hispanic, or Native American, and they are not always held to the same

standards as other students. But a recent series of lawsuits has challenged this kind of affirmative action, and the courts have begun siding with white students who claim reverse discrimination after they are denied admission.

Just how much these court victories are responsible for the declining minority enrollment in medical schools is unknown. But since the first lawsuit was lost in 1996 by the University of Texas, admission deans across the nation have begun re-vamping how they assess applicants.

New systems tend to reduce the tradi-

tional emphasis placed on undergraduate grade point average and standardized test scores like the MCAT—measures that tend to favor whites—and factor in less tangible attributes like altruism, integrity, and cultural competency that seem to place African-Americans and Hispanics on a more even playing field with their Anglo and Asian peers.

Although minority advocates question whether this paradigm shift is enough to reverse recent admission declines, conservatives who are leading the charge against affirmative action support the



Dr. Preston Phillips, a Seattle orthopedic surgeon says, "It's not a question of just service. We care for people. And you cannot care for people unless you care about people. Not every physician understands that."



Dr. Rene Rodriguez, an orthopedic surgeon in Miami and the president of the Interamerican College of Physicians and Surgeons, says that as long as so few people of color are reviewing applicants, the system is unlikely to

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DIVERSITY IN MEDICINE

Continued from previous page

new approach. Any system that is race neutral, even if it results in additional minority admissions, is legal as long as it does not discriminate based on skin color, they say.

"You and I could come up with 1,000 good reasons to discriminate based on race," says Curt Levey, a spokesperson for the [Center for Individual Rights](#), a law organization that sued both the University of Michigan and the University of Washington because of their admission policies.

"Medical schools are going to think the public health is a compelling reason. But not every beneficial reason you come up

with meets the test of strict scrutiny under the Constitution."

In March, the Center for Individual Rights won its federal suit against the University of Michigan Law School. The center's case against the University of Washington has not yet been decided. Neither of these cases, nor a similar one in Georgia, involve medical schools. But legal experts say that does not matter: These cases place all admission policies that use race as a criteria on trial. Should any reach the U.S. Supreme Court, its decision will

affect all educational institutions.

Recent gains now lost

During the first half of the 1990s, medical school enrollment of under-represented minorities rose at levels not seen since the late 1960s. When the 1990s began, the nation's 126 medical schools annually were admitting 1,470 under-represented minorities. But by 1994, those numbers rose a whopping 38 percent to an all-time high of 2,022.

This drastic increase gave minority

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properly consider the intangible attributes minorities offer and the unique medical needs that exist in minority communities.



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Dr. Gregory Strayhorn, a primary care physician and the chair of the school of family medicine at Morehouse College in Atlanta, says programs to assist minority students academically are important. "If medical schools work with undergraduate schools in their area and also down as far as high school, pipeline programs will begin to pay off within a decade. My sense is if these schools started this two decades ago, they would be reaping these benefits."

DIVERSITY IN MEDICINE

Continued from previous page

advocates reason to believe the medical industry had turned a critical corner, and the [American Association of Medical Colleges \(AAMC\)](#) boldly predicted minority enrollment could reach 3,000 by the turn of the millennium.

But a funny thing happened on the way to the year 2000. The nation's political bent turned conservative, and the combination of a landmark anti-affirmative-action initiative in California and race-based lawsuits filed in Texas, Georgia, Washington, and Michigan began turning the medical-school enrollment tide.

Minority matriculation stayed virtually stable from 1994 to 1995 (2,022 vs. 2,021) but then the bottom began to fall out. Between 1995 and 2000, the number of under-represented minorities entering U.S. medical schools declined every year except one, to the point where only 1,728 enrolled in 2000, the last year statistics were available.

This 15 percent decline virtually wiped out the entire decade of gains, pushing minority enrollment back to levels not seen since 1991. If this trend continues, diversity advocates believe minority patients will suffer for two reasons: Minority doctors open practices in minority neighborhoods in far greater numbers (nearly three-to-one) than do whites, and there won't be enough African Americans or Hispanics involved in the medical industry to ensure that white physicians know enough about these cultures to provide them proper care.

"Much of the education that goes on in a profession has to do with the transfer of information among colleagues," says Dr. Michael Scotti, a family practice physician and the vice president of the [American Medical Association's](#) professional standards division. "The less diverse your colleagues, the more likely you are to have the lacuna of influence. So the fallout (of an under-represented minority physician work force) would be negative for patients.

"There have been affirmative action programs in American medical schools for 30 years, and they have been remarkable for their failure," Scotti adds. "The only thing that happened is there are now a lot more women and lot more Asians. But in terms of African Americans and Hispanics, nothing has happened."

African Americans currently make up about three percent of the physician work force even though blacks represent about 13 percent of the nation's population. About five percent of U.S. physicians are Hispanic, while 12 percent of the population is Latin American.

A more human approach

For years, medical schools have used MCAT scores and GPA as the main standard by which they view applicants. Under-represented minorities perform lower in these areas. Even when minority students come from middle-class families, disparities persist. Within every income band, under-represented minorities have lower average scores than do both whites and Asians.

To ensure strong minority enrollment, medical schools must use other factors to admit students. After the civil rights movement, many medical schools either established separate admissions committees that reviewed minorities or granted them additional points to make up for their lower scores.

Medical schools believed this two-tiered system was supported by a landmark 1978 Supreme Court case ([Bakke vs. University of California-Davis School of Medicine](#)) that outlawed race-based quotas but stated race may be used as a "plus factor" in admissions considerations.

The court, however, left murky the details of how race can be used.

After the Bakke decision, schools abolished quota systems but continued to admit a similar percentage of minorities each year. Not surprisingly, new lawsuits soon ap-

peared. By the mid-1980s, lower federal courts began ruling against universities. Both federal and state politicians soon joined the fray. In 1996, under the guidance of then-Governor Pete Wilson, California's higher-education system, which includes five medical schools, abolished race as a consideration for admission. A Washington State voter referendum accomplished the same end two years later.

To combat this groundswell of anti-affirmative-action efforts, some medical schools have begun de-emphasizing MCATs and GPA, broadening their admissions criteria to include a number of "nongenerative" human attributes. Applicant interviews now play a larger role in admissions because these schools now assess qualities like a commitment to serve others, life experiences, and integrity. They also give weight to a student's desire to become a primary-care physician and his willingness to work in underserved areas.

By emphasizing these and other altruistic attributes, a medical school catches an increased number of minority candidates in its net, says Dr. Joyce Wahr, an anesthesiologist and assistant dean of admissions at the University of Michigan Medical School.

"We tend to take people with moderate board scores and a high interview score over people with high board scores," Wahr says. "If the students look exactly like each other, the person with the higher board scores will probably get the nod. But they usually don't look just like each other."

Michigan began emphasizing these attributes before both its law school and undergraduate university were sued, Wahr says. Now that the legal heat is on, she expects this policy to insulate the medical school from any fallout.

"The medical school's mission statement talks about patient care and providing service of the highest quality to the people of the State of Michigan," Wahr says. "Our customers are not our students. Our cus-

DIVERSITY IN MEDICINE

Continued from previous page

tomers are the state's patients. That suddenly makes it a different ball game."

Center for Individual Rights spokesman Levey agrees this approach can help insulate schools against lawsuits. Affirmative action programs are losing court battles because universities lean too heavily on test scores and GPA, which favor whites, rather than broader admission criteria that are race neutral, he says.

"Nobody says (test scores and GPA) have to be the big factors that they are," Levey says. Schools can use other factors "as long as they can prove they are not really just a smoke screen for racial preferences. If you are generally motivated to increase service to under-represented areas, regardless of whether they are white areas like Appalachia or minority-dominated areas like inner cities, and the policy is race neutral on its face, there would not be any legal problem with it."

Minorities also hale this approach.

Standardized tests are not meant to evaluate whether a candidate has both the aptitude and perseverance to succeed in medical school, minorities say. MCATs and GPA also do not measure the kind of person a student is, or whether she contains the intangible skills necessary to be a good doctor, they say.

"We are in the service industry," says Dr. Preston Phillips, a Seattle orthopedic surgeon. "But unlike the restaurant business where you can just put on a plastic smile and make sure the patient's tablecloth is clean and the wine is chilled and delivered on time, this is a different industry. It's not a question of just service. We care for people. And you cannot care for people unless you care about people. Not every physician understands that."

Starting at the top

Although medical school officials say they now understand the value of non-cognitive attributes, minority advocates question

their resolve to consider those that are unique to Hispanics, blacks, and Native Americans. A recent survey of the racial makeup of medical school admission committees not only showed the vast majority

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of people making decisions are still white— 51 percent of admission committees contained one or no under-represented-minority doctors— but they also show few minorities are sitting in the dean's chair.

As long as so few people of color are reviewing applicants, the system is unlikely to properly consider not only the intangible attributes minorities offer, but the unique medical needs that exist in minority communities, says Dr. Rene Rodriguez, a Miami orthopedic surgeon and the president of the [Interamerican College of Physicians and Surgeons](#), an Hispanic medical association with more than 4,000 members.

"This is a battle where you cannot go from the bottom up," Dr. Rodriguez says. "Thirty years ago women in this country only comprised about five percent of medical-school attendants. Now if you go to all the admission programs, there is a middle-aged women in charge of that office. Guess what happened? Women in medical schools today are more than 50

percent of the class or close to it. Do you have to be a rocket scientist to figure this out? If you put an African American or an Hispanic in charge of that office you will see the same thing happen.

"If you don't sit at the table, then you are on the table," Rodriguez adds. "And when you are on the table, everybody is going to slice you over. But if you sit at the table, then you have the knife and you can cut a little bit for yourself."

Another piece to the enrollment puzzle is developing efforts to increase the number of minority students who seek a career in medicine, says Dr. Gregory Strayhorn, a primary care physician and the chair of the school of family medicine at Morehouse College in Atlanta. To do this, medical schools must reach out not only to college undergraduates, but high school and possibly even younger students to help them better prepare for a career in medicine, he says.

The development of preadmission programs is necessary because once minorities reach college, many have difficulty with science courses that are prerequisites to medical school, Strayhorn says. Without help, these students—many of whom have the aptitude but not the academic background to become doctors— will never stand a chance, he says.

Medical schools that sponsor these programs tend to admit a higher percentage of minorities for two reasons, Strayhorn says. Not only are a greater number of minorities in their area better educated and therefore able to meet admission standards, but medical school admission officials are comfortable accepting these students if they have low MCATs or GPAs because they trust successful completion of these preadmission courses demonstrates ability, he says.

"Most of these students have the aptitude but they have not demonstrated the performance for one reason or another," Strayhorn says. "Having them perform very

DIVERSITY IN MEDICINE

Continued from previous page

well (in these programs) gives the admissions officer more comfort that they will perform well in medical school. If medical schools work with undergraduate schools in their area and also down as far as high school, pipeline programs will begin to pay off within a decade. My sense is if these schools started this two decades ago, they would be reaping these benefits.”

There are other efforts that medical schools could undertake to help increase minority enrollment that won't get them in legal trouble, diversity advocates say. Developing strong mentor programs that help support minority students once they arrive, reaching out to high-school advisers so they don't discourage minorities from pursuing science-related careers after early academic setbacks, and lowering the institution's self-imposed minimum MCAT levels would all help African-Americans, Hispanics, and Native Americans gain greater access to a medical career, they say.

But first and foremost, the people who run medical schools not only have to want to increase the minority pool, they also have to be willing to alter how their admission programs work, says Jack Lanier, the chair of the [Association of Teachers of Preventative Medicine's](#) committee on minority affairs. The civil rights movement is now about 40 years old, but that should not make people believe that its goals can be achieved without continued assistance, he says.

“There is a feeling that we have come a long way so there really isn't the urgency or the real need to make minorities as high a priority as they were in years past,” Lanier says. “It is a perception, but it is not a reality. Progress has been made, but it is episodic and it is ad hoc. It is certainly uneven across the board.”

If no one makes minorities a priority and attitudes don't change, “people will be talking about these things five years from today with very little progress having been

made in the interim,” Lanier adds. “There is no magic bullet, and there is no quick fix. We know what the barriers are. We know the issue. It has been with us for a while. The question is how can we bring to bear the stakeholders and special interests who are willing to make this both a national and local priority.” ■

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Taking it to the Courts

Affirmative action—once the prize of the civil rights movement—is now under fire.

DIVERSITY ADVOCATES ARE QUICK TO point out that the vast majority of U.S. medical schools fail to enroll under-represented minorities at rates that come anywhere close to their proportion in the general population. They widely believe the country needs more than twice as many African-American and Hispanic physicians and three times as many Native American physicians than there are today to best serve the nation's future medical needs.

When minority medical school admissions rose during the early 1990s, some believed the United States was on its way to achieving these goals. But at the time when the greatest numbers of minorities were attending medical school, their matriculation was challenged by what some believe to be an organized attempt through both the courts and political arenas to eliminate the very affirmative-action programs that contributed to these increases.

The following is a brief look at the court cases and political initiatives that have shaped the medical school diversity landscape.

1868: The [14th Constitutional Amendment](#) establishes equal protection for all U.S. citizens under the law.

1964: Congress passes the [Civil Rights Act](#). It prevents discrimination by any program receiving federal financial assistance, which includes all medical schools.

1978: The U.S. Supreme Court ruled that white medical-school applicant Alan [Bakke](#) was unjustly denied admission to the University of California-Davis Medical School. The court ruled the school's policy of setting aside a specific number of first-year placements for under-represented minorities was unconstitutional. The court, however, also states that race may be used as a "plus factor" during admissions as long as the policy serves a "compelling state interest" and is "narrowly tailored" to achieve that goal.

1995: the [Board of Regents of California's](#) higher-education system, which includes five medical schools, abolishes the system's ability to use race during admissions. The ban includes a prohibition of actively recruiting minority students solely because they are minorities.

1996: California-voter initiative [Proposition 209](#) confirms the Board of Regents actions, which takes effect in 1997. The initiative not only abolishes the use of race as an admissions factor to schools but also in the operation of both public employment and public contracting.

1996: Four white applicants to the University of Texas Law School represented by the Center for Individual Rights win a reverse-discrimination suit in the Fifth District Court of Appeals. The justices rule that diversity in higher education does not represent a compelling state interest.

1998: [The First Circuit Court of Appeals](#) invalidates the prestigious Boston Latin School's affirmative-action policy, even though a judicial order had once been required to ensure the private high school's desegregation.

1998: Washington State voters pass [Initiative 200](#), a voter referendum similar to California's Prop 209.

1998-99: Legislators in more than a dozen states introduce anti-affirmative action bills, starting a trend that continues today.

1999: A Washington State district court denied the legal motions of both the University of Washington Law School and the Center for Individual Rights in a reverse discrimination case filed by three white applicants who were denied admission to the law school. The court also stayed the trial, which has yet to begin as the two sides continue to pursue appeals of their motions.

2001: Barbara [Grutter](#), a 47-year-old white woman represented by the Center for Individual Rights, wins a four-year court battle against the University of Michigan Law School. A U.S. District Court judge found that 'the practical effect of the law school's policy is indistinguishable from a straight quota system,' and ordered the school to stop using applicants' race as a factor in admissions.

2001: The 11th Circuit Court of Appeals upholds a lower court ruling that found three white female students were discriminated against when they were denied admission in 1999 to the University of Georgia. The lower court found the university's admission policy unlawful because student-body diversity is not a compelling interest under the U.S. Constitution. The appeals court, however, did not decide that issue. Instead it found the university's policy of awarding a diversity bonus to "each and every" non-white applicant was not narrowly tailored enough to achieve a compelling state interest in the first place. ■