Affirmative action in medical school admissions:
Minority underrepresentation in medicine

Lois W. Choi

The author is a member of the Class of 2002 at Jefferson Medical College. This paper won first prize in the 2000 Alpha Omega Alpha Student Essay Competition.

> *The great majority of Americans are . . . uneasy with injustice but unwilling yet to pay a significant price to eradicate it.*
>
> —Martin Luther King, Jr.[1]

Medical education is among the most rapidly changing fields of higher education today. It is being adapted to suit new developments in research, technology, politics, and economics. Both the content and the structure of the undergraduate medical curriculum continues to evolve in an effort to train students to be the kinds of doctors our society requires in an age of rapid social and technological advance. However, in spite of the continuing progress in medical education in changing responsively to the society it is to serve, the field has remained relatively slow to respond to the demands of what is an increasingly multicultural society. While it is true that there continues to be active dialogue concerning diversity and cultural sensitivity in medical education as well as in medicine at large, few programs or policies have been implemented successfully to promote these currently important issues. In short, while many physicians and medical educators agree that achieving diversity and developing cultural sensitivity is a valuable end, few agree on what means can be employed towards that end.

Affirmative action has been a highly polarizing and controversial issue at all levels and in all fields of education. It has, however, a special relevance in medical education. The landmark case on the issue, *Regents of the University of California* v. *Bakke*, concerned affirmative action in medical school specifically. In the late 1970s, Allan Bakke, a 32-year-old engineer, sued the University of California under the claim that the university's affirmative action policies violated his rights under both Title VI of the Civil Rights Act of 1964 and the equal protection clause of the fourteenth amendment to the U.S. Constitution. After Bakke had been denied admission to the medical school at the University of California at Davis twice, he discovered that the medical school admissions committee employed a quota system for minority students. Under this system, the school reserved a number of spaces in each entering class for students of specific minority groups and admitted candidates from these minority groups with scores and grades lower than the scores and grades of the general pool of admitted students. Ultimately, a narrow majority of the U.S. Supreme Court found in favor of Bakke, ruling that the specific admissions policy employed by the University of California was in fact unlawful, but no majority could agree on an opinion on affirmative action in general. In his concurring opinion, Justice Lewis Franklin Powell wrote that the use of race-based quotas in an admissions program did in fact constitute discrimination. However, Powell also noted that diversity in the student body is "a constitutionally permissible goal for an institution of higher education." To elaborate this point, Powell wrote, "The 'nation's future depends upon leaders trained through wide exposure' to the ideas and mores of students as diverse as this Nation of many peoples."[2] Thus, although the court found the school's use of quotas to be discriminatory and unlawful, they did not declare race to be an unsuitable factor in admissions considerations. According to Powell, race could be considered a "plus" for a particular applicant.[2]

The case of the *University of California* v. *Bakke* condemned a certain type of affirmative action, but nonetheless upheld the ends to which affirmative action is employed, namely diversity within universities aimed at producing graduates that are both aware and understanding of the differences among individuals in our multicultural society. Since *Bakke*, the task for society has been to determine what type of affirmative action program would be both lawful and effective in achieving the worthy end of maintaining diversity in higher education. Two decades later, we still have not come to a consensus. Twenty-two years after *Bakke*, affirmative action continues to be a divisive and apparently insoluble issue.

According to current demographic trends, it is projected that "the minority population in the United States will increase by 60% by the year 2010."[3] Currently, minorities, including African Americans, Native Americans, Mexican Americans, and mainland Puerto Ricans (referred to collectively as Underrepresented Minorities—URMs) are grossly underrepresented in the medical profession. Although these URMs constitute at least a quarter of the U.S. population, they only make up approximately 8 percent of our nation's practicing physicians.[4] URMs are similarly underrepresented in almost all health professions.[5] Given the projected demographics for the next decade, it is likely that the underrepresentation of URMs will worsen in the absence of any deliberate intervention aimed at increasing admissions of URMs into medical training programs.

In recognition of this problematic disparity, Jordan J. Cohen, president of the Association of American Medical Colleges (AAMC), initiated *Project 3000 by 2000*, an effort to increase minority enrollment in medical schools by (1) emphasizing the importance of affirmative action in medical school admissions, and (2) fostering an interest in medicine among URM high school and college students.[6] The first component of this project has encountered massive obstacles in light of the recent grass roots backlash against affirmative action. In 1996, Californians voted to pass Proposition 209, which rendered unlawful several important affirmative action policies employed by admissions committees in the

state. Additionally, in the same year, in its ruling on *Hopwood* v. *State of Texas*, the Fifth Circuit U.S. Court of Appeals declared the use of differing test score and grade point average (GPA) requirements for applicants of different ethnic groups unlawful in the states of Texas, Mississippi, and Louisiana. Between 1996 to 1997 alone, the number of medical school applications submitted by URMs declined markedly: African Americans by 10.4 percent, Mexican Americans by 13.8 percent, and Puerto Ricans by 16.2 percent. Notably, 40 percent of the decline of minority applications occurred in California, Texas, Louisiana, and Mississippi.[7]

Those recent statistics demonstrate the crucial role that affirmative action plays in medical school admissions. With the repeal of affirmative action policies in four states, the pool of minority applicants to medical schools in those states has been greatly affected. According to the AAMC, "17 000, or 40%, of 40 000 US-trained physicians from underrepresented minorities would not now be in practice if it had not been for affirmative action."[7] Given those findings, it appears that the most effective plan for addressing the problem of the severe and worsening underrepresentation of URMs in the medical profession is to protect and expand affirmative action policies in medical school admissions.

It is easy to argue that affirmative action is strategically effective for combatting the problem of underrepresentation. Making the case that it is politically and philosophically acceptable, however, is much more difficult. To begin, it is appropriate to step back and examine the importance of diversity in medicine. On the surface, the wide disparity between the representation of URMs in the medical profession versus in the population at large seems to be a problem. But what makes it a problem? Does it have any real effects on the delivery of quality health care for the public? Does it merely offend our politically-correct sensibilities, or does it reflect real underlying injustices within the system?

The most compelling statistic demonstrating the need for increased minority representation in medicine is the greater tendency of URM physicians to serve underserved segments of the population. The fierce competition present today in medical school admissions, postgraduate training, and post-training employment suggests that there are too many doctors. But the truth is that there are too many of one kind of doctor, the kind of doctor who wants to practice in a specialized field in a metropolitan center, and not enough of those who want to serve the urban and rural poor. It seems most logical to attempt to achieve a balance between candidates likely to enter the more competitive, prestigious, and lucrative sectors in medicine and those likely to address the needs of the underserved, rather than to control the number of people admitted into training to become a physician. Affirmative action becomes important here. One way that admissions officers try to identify candidates likely to serve the underserved is to look for compassionate, civic-minded individuals who have demonstrated their commitment to serving the disadvantaged. Although this effort is likely to achieve a more compassionate medical work force, it is not guaranteed to produce doctors who are truly committed to serving the underserved. A study conducted by Sonia Crandall, Robert Volk, and Vicki Loemker compared the attitudes of first-year medical students about serving the medically indigent to the attitudes of fourth-year students on the same subject. The investigators found that fourth-year students' attitudes were significantly less favorable than those of first-year students.[8] Their findings suggest that a student may begin medical school with intentions of serving the medically indigent, but that the intention generally dissipates by the fourth year of the undergraduate medical experience. The researchers ask, "Are we training socially responsible physicians?" Whether or not the reason for the difference in attitudes in the first year and fourth year is attributable to training is not clear. In general, the idealism that inspires young people dissipates over time. People become more conservative as they grow older. The real questions to ask are: What kind of commitment do the students entering medical school really have to serve the medically indigent? How much are young students' interests in serving the disadvantaged influenced by the fashionability of liberalism? How deeply does the knowledge that admissions committees value such an interest motivate students to project themselves as compassionate and civic-minded?

The factor that most reliably contributes to a true commitment to serving the medically indigent appears to be race. Data from a 1997 Graduation Questionnaire administered by the AAMC shows that URM students demonstrate greater concern for providing care and improving access to adequate health care for the medically underserved in the United States than white students. Superficially, it may seem that this difference stems at least partly from a unique empathy that URMs have for the underserved because of their similar backgrounds. However, even when socioeconomic factors are controlled, URMs showed significantly higher levels of concern about the problems of access to medical care in the United States. "1997 minority graduates from families with incomes of $50,000 and higher were nearly three times more likely than non-minority graduates to indicate they planned to locate their practice in an underserved area (40% vs. 16%)."[9] A study conducted by Howard Rabinowitz of the Center for Medical Education Research and Policy at Jefferson Medical College yielded similar results. Rabinowitz analyzed data for 2,955 physicians who had graduated from medical school in 1983 and 1984 and found that "physicians who are members of an underserved minority are three times more likely than others to provide substantial care to underserved populations."[10] Other factors demonstrated a much weaker correlation to outcomes concerning substantial service to the medically underserved.

Having grown up in an underserved area, for example, made graduates only 1.6 times as likely to serve such an area.[10] When the effects of race are separated from the effects of having a background of economic disadvantage, it becomes clear that the tendency of minority physicians to serve in underserved areas has more to do with their race than with their socioeconomic background.

Such facts validate the medical profession's need for more minority representation: not only for the cultural and social value of diversity, but, more imperatively, for supplying a need within medicine. This is not to say that minorities should have some special obligation to provide care for the underserved, but the facts clearly show that they have a strong tendency to be so committed. It is evident that race matters in the kind of doctor a candidate is going to be; it is a more reliable predictor than what an applicant may claim on an application.

To whom exactly are we referring when we speak of "the medically underserved"? The group consists of the economically disadvantaged, but, more than that, includes those who are also racially and culturally disadvantaged. Several studies have shown that the persistent racism that affects our broader culture extends also to the treatment of patients by doctors. In his paper, "Trust, Patient Well-being and Affirmative Action in Medical School Admissions," Kenneth DeVille reports:

> There are studies that suggest that physicians treating minority patients are "less likely to follow guidelines from nationally recognized organizations for health promotion and disease prevention" than are physicians who care for predominantly white patients. Other research reveals lower utilization rates for African Americans for ordinary components of basic medical care and reports that African American patients are more likely to feel that physicians failed to give them full information about their diagnosis, treatment and follow-up. Other studies have found that African Americans are more likely than whites to be hospitalized for avoidable conditions, may receive a lower quality of care when hospitalized, and show more instability at discharge than do other patients. African American patients receive fewer hip and knee replacements, are less likely to receive prophylactic therapy for HIV, are less likely to undergo surgical resection for colorectal cancer, and are less likely to receive angiography, angioplasty and coronary artery bypass surgery than white patients. In contrast, African Americans appear more likely to receive procedures patients typically wish to avoid, lower-limb amputation, bilateral orchiectomy, and cesarean delivery. . . . The authors concluded that such findings 'may represent overt prejudice on the part of physicians or, more likely, could be the result of subconscious perceptions rather than deliberate actions or thoughts.[11]

This review of the studies on the treatment of African American patients by physicians only brings to light what we already suspect: medicine is not immune to racism. The problem of racism in medicine is not simply one that mars our esthetic of political correctness, but is also one that has penetrating and permanent physical effects for those discriminated against by the people in whose hands they place their health.

The problem is not a temporary one that will disappear when racism subsides, if it ever does. The American medical profession has a longstanding history of shameless abuse and exploitation of African Americans that dates back to the founding of this country.[12] Such instances of stark racism are not just remnants of a distant past. As recently as 1972, at the end of the Tuskegee experiments, the health of black men was compromised for the sake of the advancement of medicine. Even today there is no shortage of incidences of racist and prejudicial treatment of minority patients by doctors. Although it may be true that most doctors are in fact benevolent and equitable in their treatment of all patients, given the history outlined here, the mere presence of the most isolated incidences of racial prejudice in medicine keeps African American suspicion of medicine sustained. Both the deep-seated mistrust of African Americans for the medical profession and the actual racism and prejudice influencing physicians in their treatment of those patients combine to produce a group of people who tend to be more poorly served by the medical community.

What these patients need most are physicians whom they can trust. Louis Sullivan, former U.S. Secretary of Health and Human Services, has said that the United States has a "social and moral obligation to cultivate physicians who can relate to that segment of the community."[11] In short, given the mistrust that minorities sometimes have towards physicians, diversity in the medical profession is indeed an important goal. Since affirmative action has been thus far the only effective means of achieving diversity, it should be legally sustained and employed in medical school admissions policies.

In considering the health care needs of the public, we must also expand our scope to consider the health of the entire population, not just those underserved. The question here becomes, "Is affirmative action and diversity, the end that it serves, bad for the health of the greater population?"

Critics argue that affirmative action is in fact bad for the health of the public because it produces substandard doctors admitted to medical school under substandard qualifications. As one critic put it, "Minority communities and poor families don't need black doctors. They need good doctors."[11] But what should be suspect is not the so-called un-

derperformance of minority students as much as the underlying assumptions about the criteria that persistently rank them as substandard. Currently, grade point average (GPA) and Medical College Admission Test (MCAT) scores are the primary criteria for medical school admission. People assume that strong GPAs and MCAT scores qualify a candidate to be a physician. The truth is that, historically, MCAT scores were not intended to be predictors of who would ultimately make the best doctors. The test was introduced in the 1950s at a time when admission to medical school was not competitive and attrition rates were high due to the presence of underqualified students. The MCAT was used to ensure that medical students were minimally qualified to study medicine. However, with the rise in competition for medical school admission in the 1960s and 1970s, average MCAT scores rose above the level needed to "guarantee reasonably successful completion of a course of medical studies."[11] What this means is that even though minority students may score lower on average than white students on the MCAT, they are not "substandard" in terms of this isolated criterion. The fact is that all physicians must pass the U.S. Medical Licensure Examination (USMLE) to practice medicine. In this context, affirmative action does not create substandard doctors. Rather, it provides minorities with the opportunity to be trained and prepared to be physicians. Passage of the USMLE is what qualifies them to practice medicine.

Some argue that even if all doctors are at least minimally qualified, why not have the most qualified, meaning those with the highest scores. The fact is that affirmative action students do not underperform relative to non-affirmative action students, either in medical school or in practice. In a 1997 study conducted at the University of California, Davis, School of Medicine, Robert Davidson and Ernest Lewis analyzed the performance of all affirmative action and special consideration admissions students over a period of 20 years. Of all students studied, 20 percent were special consideration admissions, meaning that they were students who had a GPA less than 3.0 and MCAT scores of less than 10 on each of the 4 subsections of the test. URMs constituted 47.7 percent of special consideration admissions and only 4.0 percent of regular admissions. In the final analysis, special consideration students did nearly as well as regular admissions students. Ninety-four percent of special consideration students graduated and 97 percent of regular admissions students graduated. Regular admission students were more likely to receive honors, but there was no difference in failure rates between the two groups. Additionally, there were no significant differences in the performance of the students in the two groups in their residency training performance, according to the evaluations of their residency program directors. Davidson concluded,

> **Criteria other than undergraduate grade point average and Medical College Admission Test scores can be used in predicting success in medical school. An admissions process that allows for ethnicity and other special characteristics to be used heavily in admission decisions yields powerful effects on the diversity of the student population and shows no evidence of diluting the quality of the graduates.**[13]

What Davidson showed is that undergraduate GPA and MCAT scores are not, in fact, bottom-line determinants of the quality of graduates produced.

All medical schools employ special admissions criteria related to state residency, alumni connections, postbaccalaureate affiliations, extracurricular interest, or future professional commitments, among others. Such criteria are less frequently challenged as adequate reasons for admitting students than is race. Racial diversity enhances the experience of all medical students in their education, produces doctors that underserved patient populations trust, and more equitably reflects the make-up of the population at large; these are compelling reasons to admit applicants who may not be as competitive in terms of raw scores. In the absence of evidence showing that affirmative action special admissions produces doctors less qualified than those admitted by special considerations influenced by any criteria other than race, the assumption that affirmative action results in bad doctors is not well founded.

The facts presented here support the claim that employing affirmative action in medical school admissions is both efficacious and valuable in terms of promoting diversity within the medical profession. However, affirmative action is admittedly not without faults. As some critics argue, it is a means towards racial equality that paradoxically relies on a system of racial preference. While it is true that such a characterization makes affirmative action seem hypocritical, it is important to acknowledge that preference made in light of disadvantage is different and unique from both preference made in the context of advantage or preference based on more arbitrary distinctions. It is arguable that being a racial minority subject to prejudice and with a long history of discrimination and abuse is not trivial. That history, those facts, can be justifiably considered not only in judging the merit of an individual's accomplishments, but also in predicting what kind of doctor that individual will be.

In his speech, "Where Do We Go From Here: Chaos or Community?," Martin Luther King, Jr. made the statement, "The great majority of Americans are . . . uneasy with injustice but unwilling yet to pay a significant price to eradicate it."[1] As a professional community, we need to both acknowledge the racial inequity that exists within our ranks, and to apply appropriate measures to move towards eradicating it. Affirmative action is among the most effective and

direct means of addressing the problems of racial disparity within the profession. It should be advocated and implemented so that we will be able to provide our nation with the kind of doctors it needs.

References

1. King ML Jr. Where Do We Go from Here: Chaos or Community? Boston: Beacon Press; 1967. p. 11.
2. University of California Regents v. Bakke, 438 U.S. 265; 1978.
3. Teaching and learning of cultural competence in medical school. Contemp Iss Med Educ 1998; 1: 1–2.
4. Cohen JJ. Time to shatter the glass ceiling for minority faculty. JAMA 1998; 280: 921–22.
5. Clawson DK. Challenges and opportunities of racial diversity in medical education. Clin Orthopaed Rel Res 1999; 362: 34–39.
6. Cohen JJ. Project 3000 by 2000 and health care reform. Acad Med 1994; 69: 228.
7. Affirmative action. Lancet 1999; 353: 1.
8. Crandall SJS, Volk RJ, Loemker V. Medical students' attitudes toward providing care for the underserved: Are we training socially responsible physicians? JAMA 1993; 269: 2519–23.
9. Nickens HW. Questions and Answers on Affirmative Action in Medical Education. Washington (D.C.): Association of American Medical Colleges; 1998.
10. Brunk D. Caring for the underserved: Four predictive factors. Fam Pract News 2000 Jan 1: 46.
11. DeVille K. Trust, patient well-being and affirmative action in medical school admissions. Mt Sinai J Med 1999; 66: 247–55.
12. Gamble VN. Under the shadow of Tuskegee: African Americans and health care. Am J Public Health 1997; 87: 1773–78.
13. Davidson RC, Lewis EL. Affirmative action and other special consideration admissions at the University of California, Davis, School of Medicine. JAMA 1997; 278: 1153–58.

Author's address is:

320 S. 10th Street, Apt. 300
Philadelphia, Pennsylvania 19107
E-mail: lois.choi@jefferson.edu

By and about the author

I was born in the winter of 1973 in Seoul, Korea, the second child of a young medical school graduate and his wife. At the age of one, I journeyed west with my family to embark on a new life in America as my father began his residency training at Thomas Jefferson University in Philadelphia, Pennsylvania. I spent my college years at Harvard University, engaged in an interdisciplinary course of study in the social sciences. In 1996, I graduated with a B.A. in social studies and remained at Harvard for two more years to complete my premedical requirements as well as a Masters degree in education. I have now come full circle and returned to Philadelphia to prepare for my own career in medicine at Thomas Jefferson University. In the future, I plan to pursue a career in psychiatry and also to maintain an active involvement in the field of medical education.