Finishing the Bridge to Diversity
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I want to call you all to action.
To take firm leadership on this issue. Leadership in educating the best doctors. Leadership in providing quality health care. And leadership in finding answers to major health problems.

For my part today, I have chosen to discuss a more longstanding challenge. One that has been with us much longer than either managed care or Web pages. I want to talk about finishing the bridge to diversity. This bridge-building challenge differs a lot, I think, from others that are commanding so much of our attention. For one thing, although the tools we need for this work stem, as always, from carefully honed analyses of the data, those tools must be sharpened for this particular task by something in addition to data — by deeply felt passion.

My plan is to set forth the reasons why I think achieving diversity in medicine is so critical. I want to call your attention to some historical arguments, some practical arguments, and some moral arguments. In the end, I want to call you all to action. To take firm leadership on this issue. Leadership in educating the best doctors. Leadership in providing quality health care. And leadership in finding answers to major health problems. None of these goals can be achieved, in my judgment, without taking leadership to bridge the appalling diversity gap that still separates medicine from the society it professes to serve.
The Challenge for Academic Medicine

To establish the context for my remarks, let me review some familiar facts. The population of the United States continues to grow and will do so well into the next century (Figure 1). The truly dramatic change to come, however, is not the size of our population but its composition. Our population is growing older, as everyone knows, and it also is growing racially and ethnically more diverse (Figure 2).

Minority populations are increasing much more rapidly in this country than is the majority white population. As shown in Figure 2, between 1980 and 1995, while our country’s white population grew by about 12%, our black population increased twice as fast, by about 24%; our Native American population grew by 57%; our Hispanic population, by 83%; and our Asian population, by more than 160%.

Figure 1. Growth and projected growth of the U.S. population, 1950-2050.

Figure 2. Increases, in percentages, of subgroups of the U.S. population, 1980-1995.
The result, as shown in Figure 3, is that somewhere in the middle of the next century, the majority of our citizens will be members of minority groups.

So what? What do these striking demographic trends describing the future complexion of America have to do with our responsibilities as stewards of medicine’s future? I find the answer to that question pretty straightforward. Academic medicine is, after all, largely about the future. It’s about improving the health of future generations by educating the physicians who will care for tomorrow’s children, and by discovering better ways to keep tomorrow’s children healthy. Given that our primary obligation to society is to furnish it with a physician workforce appropriate to its needs, our mandate is to select and prepare students for the profession who, in the aggregate, bear a reasonable resemblance to the racial, ethnic, and of course, gender profiles of the people they will serve. In other words, a medical profession that looks like America. We have made substantial progress on this front with respect to gender; but, as these data suggest, we’ve still got a long, long way to go with respect to race and ethnicity.

But why should anyone care if the medical profession reflects society’s racial and ethnic makeup as long as we have plenty of well-trained practitioners of whatever background? The reasons are many. Let me mention five that stand out in my mind:

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Achieving Justice and Equity

First is the simple matter of justice and equity. The medical profession, and the health professions in general, occupy a lofty status in American society, and offer those who pursue them many of the most challenging and rewarding career opportunities available anywhere. As physicians, for us to seek justice within our own profession is, I believe, only to be faithful to our cardinal commitment to respect everyone’s individuality equally.

Ensuring Access to Health Care

The second reason is a matter of improved access to health care for the underserved. Abundant data now exist to document unequivocally that black, Hispanic, and native American physicians are much more likely than whites and Asians to practice in underserved communities. Not that minority physicians are, or should be, under any obligation to do so; not that minority physicians are not, and should not be, free to settle and practice wherever and however they choose; and not that other physicians do not contribute importantly to improving access among the underserved. The simple fact is that minority physicians do so with greater predictability. And getting the job done means producing more minority physicians to lead the way.

Providing Culturally Competent Care

The third reason for increasing diversity among our students — and faculty, I might add — has to do with learning how to deliver culturally competent care. Given the expanding diversity throughout our society, all physicians of the future will need this essential skill, and must be given a strong foundation in what it means to deliver culturally competent care.

If they are truly to care for their diverse patients, physicians of whatever background must have a firm grasp on how various belief systems, cultural biases, family structures, historical realities, and a host of other culturally determined factors influence the way people experience illness and the way they respond to advice and treatment. Such differences are real and translate into real differences in the outcomes of care. But should you find this argument unconvincing, let me remind you of a pragmatic consideration — of the
increasing importance of customer satisfaction. As our patients become culturally more diverse, our ability to meet their culturally determined expectations will strongly influence their choice of caregivers. The connection between all of this and the need to expand diversity in the educational environment is clear. Learning how to deliver culturally competent care means learning medicine with students and from faculty who are themselves emblematic of society’s diversity. Textbooks alone just won’t cut it.

*Setting an Appropriately Comprehensive Research Agenda*

A fourth reason for addressing diversity has to do with our research agenda. Our society as a whole is plagued by many unsolved health problems, many of which swirl disproportionately around our minority populations. Our country’s research agenda is set in large measure by those who have chosen careers in investigation. Individual investigators, in turn, tend to do research on problems that they “see” and have an interest in. And what people see, and what tickles their fancy, depends to a great extent on their particular cultural and ethnic filters. Recognizing all these truths leads to the reality that finding solutions to our country’s most recalcitrant health problems, even being able to conceptualize what the real problems actually are, will require a research workforce that is much more diverse racially, ethnically, and by gender than we now have. Creating that workforce begins with ensuring diversity among those admitted to our M.D. and Ph.D. educational programs.

*Securing the Talent Needed To Lead the Health Care Enterprise into the Twenty-first Century*

My fifth and final reason for the need to achieve diversity in the medical profession relates to management of the health care system. Physicians must continue to exert leadership — some would say re-exert leadership — in the management of the health care enterprise, especially now that that enterprise is becoming increasingly corporatized. But assuming management responsibility for a system destined to serve the health care needs of an increasingly diverse people is a job that can only be done well by equally diverse management teams. We must draw the future physician leadership for our health care sys-
tems — as we must for all other professional and non-professional sectors of the American economy — from a richly diverse pool of talent, adequately reflecting our country’s gender, racial, and ethnic mélange. It’s simply smart business to do so.

So, five reasons stand out for seeking diversity in the medical profession: achieving justice and equity; ensuring access to health care; providing culturally competent care; setting an appropriately comprehensive research agenda; and securing the talent needed to lead the health care enterprise into the twenty-first century.

Taking a Historical Look

How are we doing? Let’s take a historical look. Until the mid 1960s or so, the racial — and, of course, gender — composition of medical school classes, and hence of the medical profession, was composed, monotonously, of white men. As shown in Figure 4, despite a progressively expanding, double-digit presence in our population, groups that we now designate as underrepresented minorities made up only about 2% of medical school matriculants, and three-quarters of those attended either Howard or Meharry. The typical medical school of that era admitted one minority student every other year. I graduated from medical school in 1960, one of the off years. In my class of

#### Seeking Diversity in the Medical Profession Will Help Achieve:

- Just and equitable access to rewarding careers
- Improved access to health care for the underserved
- Culturally competent care
- A comprehensive research agenda
- Use of the rich and diverse pool of the nation’s talent to better manage the health care system.
there were 134 white men and six white women. And that was a banner year for women.

In my 1965 residency class, there were no women (except nurses), no blacks, no Hispanics, no Native Americans, not even an Asian American. Racial segregation was as fully evident in medicine as it was in virtually every sector of American society, just as it had been for many preceding decades. But things began to change in the late 1960s. The civil rights movement, the assassination of Martin Luther King, and a rash of urban riots woke many people up. And academic medicine was among the first to get the wake-up call. The result was a dramatic rise in the admission of minorities to medical schools (Figure 5). Although not shown in Figure 5, women also began to matriculate in record numbers. Was this because scores on the Scholastic Aptitude Test, grade-point averages, and Medical College Admission Test scores of women and minority students suddenly began to skyrocket. Of course not. What changed — what led to the dramatic rise in women and minority matriculants to medical school — was simply that academic medicine began to take affirmative actions to increase the racial, ethnic, and gender diversity of medical school classes.

As shown in Figure 5, enrollment of underrepresented minorities in U.S. medical schools rose rapidly to about 8% of all matriculants by the early 1970s. But, as you can see, progress on our bridge to diversity stalled in the mid 1970s, with admissions remaining virtually flat for the next 15 years or so. To make matters worse, the fraction of individuals from the same groups in the U.S. population that were under-
represented in medicine continued to grow during this period, as shown in the top line in Figure 5, increasing from 16% in 1975 to 19% in 1990. Our bridge to diversity, in other words, was less than halfway across the chasm, and the gap was widening under our eyes. Clearly it was time to call in the engineers to reevaluate our bridge-building strategy. We did so, and the result was *Project 3000 by 2000*.

**Creating Partnerships**

When Bob Petersdorf announced this important initiative at the 1991 meeting of this association just five years ago, he noted that the root cause of minority underrepresentation in medical schools in the present era is the accumulated academic disadvantages borne by too many minority young people simply because they lack access to high-quality, precollege and college educations. As a consequence, groups of applicants from the various and diverse sectors of our population do not arrive at our admission offices with equivalent academic credentials. Clearly, the only satisfactory fix for this dilemma in the long run is fundamental reform of our country’s education system.

And that is the core mission of *Project 3000 by 2000*: to contribute what we can — in concert with a host of other public and private initiatives — to the long-term solution for a very complex, multifactorial, recalcitrant social catastrophe. As you know, the *Project’s* core strategy is to effect small-scale educational reform through durable, minority-focused community partnerships, partnerships among academic medical centers and those K-12 school systems and colleges that are responsible for the academic preparation of potential underrepresented minority applicants. This is the novel element of the *Project’s* strategy: To create honest-to-God partnerships with selected feeder schools that will complement and reinforce the many useful approaches undertaken for years by many in the academic medicine community.

Special programs, including magnet health science high schools, articulation agreements, and science

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**Project 3000 by 2000**

**Mission Statement**

To eliminate the underrepresentation of blacks, Native Americans, Mexican Americans, and Mainland Puerto Ricans in U.S. medical schools.

**Core Strategy**

To effect small-scale educational reform through durable, minority-focused partnerships of academic medical centers and those K-12 school systems and colleges that are responsible for the academic preparation of potential applicants from underrepresented minorities.

**Examples of What Works**

- Magnet health science high schools
- Articulation agreements with feeder colleges
- Science education partnerships
- Early identification and fostering of interest and talent
- Relationships with mentors
education partnerships have been created to identify promising students early in the educational pipeline, to enrich the science and related offerings available to students from poorly equipped schools, to establish mentoring relationships to keep the flames of inquiry and aspiration burning intensely, and to provide adequate counseling to ensure that all the milestones on the long road to medical school are understood and met.

What happened after the launch of Project 3000 by 2000? What happened was a second dramatic upturn in the number of underrepresented minorities admitted to medical school (Figure 6). Indeed, the number began to rise almost immediately and tracked right along the trajectory toward the Project's numerical goal of 3,000 new entrants to medical school among underrepresented groups by the turn of the century. In 1994, for the first time in history, more than 2,000 underrepresented minority students entered medical school, up from fewer than 1,500 in 1990.

But how is this possible? I just got through saying that Project 3000 by 2000 was aiming at the long haul. How did it achieve such early success? I think one reason, for sure, was the new attention focused by the Project on the

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lack of adequate racial and ethnic diversity among medical students. As a result, we saw a significant increase in the fraction of underrepresented minority applicants who gained acceptance at virtually every school. As it happens, we also got a boost from the rising tide of applicants during this same period; the pool of minority applicants rose along with the pool of all applicants. Call it the Hawthorne effect if you like, but, in fact, the measurable progress made during this phase validated, once again, the power of affirmative action.

Standing the Test

The next critically important question to address, and one that the critics of affirmative action raise repeatedly, is whether the use of affirmative action as a tool, and the resulting increase in the number of minority medical students, leads to unqualified individuals becoming doctors. To raise such a question is to concede ignorance of the facts. First of all, no one in their right mind would argue for admitting anyone to medical school who did not evidence the academic skills and personal qualities necessary for completing the M.D. degree. Such an admission policy would not only violate our oath to patients, it would be a disastrous disservice to individual students. And the data clearly show that medical schools are keen to avoid this pitfall.

The vast majority of medical students from underrepresented minority groups, as is true of all students admitted to medical school, do successfully complete the rigorous requirements for graduation. Medical school admission committees cannot be commended enough for the care they take in selecting our country’s future physicians. That only a handful of students from all backgrounds, majority and minority alike, prove unable to withstand the rigors — or to meet the financial costs — of a medical education and must abandon the quest along the line, is ample testimony to the skill and wisdom of our admission committees.

But let’s return to the data for some less happy news. What is now evident, unfortunately, is that the initial upturn in the admission of underrepresented minorities following the launch of Project 3000 by 2000 leveled off in 1995, and, even more alarmingly, actually fell — by more than 100 individuals — among this year’s matriculants (Figure 7). After the historic high of 1994, something changed. Has Project 3000 by 2000 run out of steam? Quite the
contrary. We learn of more and more educational partnerships and effective programs every year. As I’ve tried to emphasize, Project 3000 by 2000 is aimed at the long haul. The returns it will have on the investments it makes in educational partnerships will accumulate slowly over the next several years, even decades. It will take at least that long to fix the pipeline, to release us from the need for short-term remedies.

And it’s precisely those short-term remedies that may well be in jeopardy. What may be running out of steam, in other words, is the oomph behind affirmative action programs, programs designed to reach out not only to those qualified young people from underrepresented minority groups who are already in the applicant pool, but also to those who should be in the pool, and to those who, through short-term academic enrichment efforts, could qualify to enter the pool. The reason for being suspicious that weakened affirmative action efforts may be the culprit here is all too obvious, given the way its use is being attacked on so many fronts.

Chilling Conclusions

For us in higher education, the Hopwood case was one of the most chilling pieces of evidence that affirmative action is under attack. As you know, the decision of the U.S. Court of Appeals for the Fifth Circuit in that case, which
was let stand by the Supreme Court, has taken away the right of faculties in Texas, Mississippi, and Louisiana to use race and ethnicity at all as factors in admission to any university program. And as of three days ago, with the passage of Proposition 209, our colleagues here in California are no longer free to consider race, ethnicity, or gender in admission decisions, in recruiting programs, or even in planning and implementing minority-targeted outreach activities, such as tutoring programs and educational enrichment courses. California, Texas, Mississippi, and Louisiana: these four states alone contain fully 35% of the minority populations that remain underrepresented among medical students, and fully 75% of those from the Mexican-American community.

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Keeping Diversity in Academic Medicine’s Future

Those who oppose affirmative action, and I know many of you do, argue either that it’s no longer needed, or that it’s ineffective, or that it’s unfair. Looking at this contentious issue from the vantage point of the medical profession, I maintain that all three of those arguments are false.

Is affirmative action in medical school admission still needed? Absolutely. Until the academic credentials of all groups in the applicant pool are indistinguishable, we simply cannot use the same criteria to evaluate all applicants. Let me be absolutely clear. Given the disparity in available measures of academic achievement among applicants grouped by race and ethnicity, there is simply no way we can select an adequately diverse class of medical students today without taking race and ethnicity explicitly or implicitly into account. Using surrogates for race and ethnicity can certainly help, but that approach is not an adequate substitute, in my mind, for being forthright about what is needed. We must continue, for as long as necessary, to reach out to those whose race and ethnicity, not their economic status alone, have subjected them to inferior academic preparations, but who, by dint of character, intelligence, and drive, are fully prepared to succeed as physicians and medical scientists.
Is affirmative action ineffective? Certainly not in medicine. Indeed, nowhere is the effectiveness of affirmative action more in evidence than in our profession. Effective not only in narrowing our diversity gap, but effective in greatly expanding access to care.

Is affirmative action unfair? How in the world can it be unfair to boost the chances of becoming a physician — to give special treatment to persons who have been subjected to obscenely unfair discrimination because of their heritage, and whose status in our democratic society remains tarnished through no fault of their own. Okay, but how about being fair to all the other applicants who don't get the benefits of affirmative action. Look, we have many more qualified applicants to medical school than we have places for them. Most applicants come away empty-handed, and do so for a whole variety of reasons. To single out affirmative action for their disappointment and plead unfair treatment just doesn't compute. If one of my kids or grandkids was rejected from medical school, I’d be damned disappointed; but if they tried to blame it on reverse discrimination, I’d say: Get a life. Because I believe it’s time already to share the wealth, to recognize that our profession needs — and our country needs — the best talent it can find from every group in our society.

The Call to Action

As much as we’d like to think otherwise, and as much as we long for the day when it’s no longer true, race and ethnicity still matter in America. To ignore that reality in deciding who deserves to be admitted to medical school is to ignore our duty as stewards of our profession’s future. I can tell you that the AAMC does not intend to ignore its duty in this arena. As you may know, late last spring we spearheaded the formation of a new coalition, Health Professionals for Diversity. Over 30 of the nation’s leading medical, health, and education organizations have signed-on to this coalition, and we all have pledged to do whatever we can (1) to make the case for diversity in the healing professions, (2) to prevent the spread of anti-affirmative action initiatives, and (3) to release the constraints that have already been imposed on many of our faculties.

We must continue to produce physicians and scientists from all segments of America. We must remember how many young minority physicians, with their many talents and abundant energy, would have been lost to us if the
enrollment practices from my era in medical school had not been reversed by affirmative action. But simply repeating the rhetoric of the 1960s will not be enough. We must face up to the fact that our society is being hampered at present by a mean-spirited backlash. Race has once again become a political “wedge” issue. A growing fraction of our citizens seems prepared to accept the views expressed by some politicians that we can abandon affirmative action efforts, that we have come far enough in undoing the ravages our society suffered during centuries of ugly subjugation by race, that our awful legacy of racial and ethnic discrimination is behind us. We have a judge in the Hopwood case, for example, who offers the opinion that race contributes no more to a person’s identity than does his or her blood type. One wonders what planet that judge is living on!

All of us must speak out to the opinion leaders and lawmakers in our communities. This is a moral issue, and it is a health issue. Hence, it is our issue. And the data are compelling. The consequence of abandoning affirmative action programs prematurely will be a reduction in the availability, and a deterioration in the quality, of health care services for everyone.

In jurisdictions like the Fifth Circuit and in California, where prohibitions have been imposed on the use of race-conscious, affirmative-action tools, we must work within the law to minimize the impact on minority enrollments. The AAMC will seek to develop and disseminate to those states whatever lawful alternatives we can find to ensure that qualified applicants from underrepresented minority groups continue to be identified and recruited to medical schools.

We must redouble our efforts on behalf of Project 3000 by 2000. We must work to accelerate the establishment of meaningful educational partnerships with pipeline schools and encourage others to join in the effort. Each of us, as citizens, needs to see our beleaguered public schools as the crucibles from which our future physicians will come, and use our privileged place in American society to be advocates and champions of education.

In short, medicine must stay the course, we must not be afraid to lead. We must finish the bridge to diversity we began to build in the 1960s. We cannot allow thoughtless attacks on affirmative action to dismantle the fledgling structure we have yet to complete, a structure without which at least some of our minority colleagues would never have attained their dreams, never have healed a patient, never have discovered new knowledge, never have led an institution, never have inspired a student, and never have graced our profession.