opportunities to undergraduate students interested in medical careers, and provide funding to expand minority faculty representation.

The enrollment of underrepresented minorities in U.S. medical schools rose rapidly to about 8 percent of all matriculants by the early 1970s (Exhibit 1). Progress stalled in the mid-1970s, however, and admissions remained virtually flat for the next fifteen years or so. At the same time, the fraction of individuals from the same groups who were underrepresented in medicine continued to grow as a percentage of the U.S. population, causing the “diversity gap” between medicine and the general public to widen even further.

A second sizable rise in minority enrollment commenced in 1990, coinciding with the inauguration of the Association of American Medical Colleges’ (AAMC’s) Project 3000 by 2000. One can only speculate as to why a project focused on long-term solutions was associated with such an abrupt upturn in the number of admissions of underrepresented minorities to medical schools. Indeed, the number began to rise almost immediately after the project was launched and tracked right along the trajectory toward the numerical goal of 3,000 new entrants to medical schools among underrepresented groups by the turn of the century. Undoubtedly, an important contributing factor was the rising tide of all applicants, minority and majority alike, as well as the continued commitment and dedication of federal Title VII programs and ongoing efforts to achieve diversity in medical education, that occurred during the early 1990s. 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. One plausible explanation for this unexpected but welcome early effect is that by focusing new attention on the lack of adequate racial and ethnic diversity among medical students, the project spurred greater effort within existing affirmative action programs.

Although minority enrollments to medical school were rising, unequal access to educational opportunities in primary and secondary schools for low-income minority students were, and still are, apparent. Project 3000 by 2000 was designed to help remedy this root cause of minority underrepresentation in medical schools. A core strategy of the project was to create small-scale educational reforms through durable, minority-focused community partnerships between academic medical centers and selected K–12 school systems and potential pipeline colleges. To implement this strategy, the AAMC—with funding from the Robert Wood Johnson Foundation (RWJF) and the W.K. Kellogg Foundation—launched the Project 3000 by 2000 Health Professions Partnership Initiative (HPPI), which continues to operate today. In 1996 the HPPI began funding local educational partnerships between health professions schools and K–12 schools around the country. Special programs, including magnet health-science high schools, articulation agreements, and science education partnerships, have been instituted 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, and to provide adequate counseling to ensure that the many milestones on the road to medical school are understood and met.

**Affirmative Action Under Attack**

In writing his opinion in support of the majority decision for the Supreme Court case, *Regents of the University of California v. Bakke*, in 1978, Justice Harry Blackmun declared, “In order to get beyond racism, we must first take account of race. There is no other way. And in order to treat some persons equally we must treat them differently. We cannot, we dare not, let the equal protection clause perpetuate racial supremacy.”

Since then, the *Bakke* decision, which allowed schools to take race into account in admissions decisions in recognition of the fact that a diverse student body enhances the educational experience of all students, has fostered affirmative action policies in higher education that have opened previously closed doors of opportunity to numerous individuals of racial and ethnic backgrounds underrepresented in medicine. Between 1978 and 1994, African American matriculants to U.S. medical schools increased from 6.4 percent to 8.9 percent and peaked at 9 percent in 1995. Over the same sixteen-year period, Hispanic matriculants increased from 3.9 percent to 6.8 percent and peaked at 7.2 percent in 1996.

The policies that helped make such increases possible came under serious attack in 1996, when the Fifth Circuit Court ruled in *Hopwood v. University of Texas* that the public universities under its jurisdiction were prohibited from taking race into account in their admissions policies. The decision affected Texas, Mississippi, and Louisiana. The same year Proposition 209 was passed in California, likewise banning the use of affirmative action in the state’s public universities. More than half of the Hispanics in the United States live in Texas and California, including an even larger percentage of school-age children. To varying extents, all schools have had declines in minority enrollment in the wake of these decisions. In studying the enrollment of minority students in California’s institutes of higher learning since Proposition 209, one researcher estimates that the University of California’s medical schools have had their “social clock” set back twenty-five years.

Thus, the annual medical school enrollment of individuals from minority groups underrepresented in medicine, which was steadily growing until 1996, has since been on a steady decline, dropping from 2,340 for the 1995–96 school year to 1,922 for the 2000–01 school year. Had the percentage of underrepresented minority matriculants simply remained at its high watermark of the mid-1990s, more than 1,400 additional minority students would, in the aggregate, now be well on their way toward becoming physicians.

Ironically, the notable recent drop in the matriculation of underrepresented minority students to medical schools provides confirmation of the power of affirmative action programs in advancing the cause of diversity in medicine.
Solutions To Medicine's Diversity Gap

In 1999 African Americans and Hispanics each constituted approximately 12 percent of the U.S. population but made up only 2.6 percent and 3.5 percent, respectively, of the physician workforce. Native Americans are even less well represented in medicine; they constitute just 0.7 percent of the population but merely 0.1 percent of America’s doctors. Comparable figures for many other minority groups, especially certain recent immigrant populations, are not available but are likely to be just as arresting.

Asians and Pacific Islanders, who constitute 3.8 percent of the U.S. population, 9.1 percent of U.S. physicians, and approximately 20 percent of the nation’s matriculated medical students, are accordingly not considered underrepresented in medicine. However, this population category consists of many ethnic communities with distinct cultures and nationalities, and we do not know the extent to which these groups are proportionally represented among physicians. Viewed individually, specific groups under the “Asian” rubric would undoubtedly exhibit varying representation in the health professions workforce, many being severely underrepresented.

Clearly, the United States faces an enormous challenge in bridging the rapidly widening diversity gap in the health professions. First and foremost, disparities at the precollege level must be addressed. Success at this level would eventually provide a national pool of students whose academic preparation for medical school (and health professions study) would not be distinguished by race or ethnicity. If students from all sectors of our population had equal access to high-quality primary, secondary, and college educations and, accordingly, presented equivalent academic credentials during the medical school admissions process, there is no doubt that the composition of medical school classes and of the physician workforce would, as a matter of course, correspond closely with that of the population at large.

But completely “leveling the playing field” to permit massive upgrading of the nation’s K–12 education systems will require a fundamental shift in public policy. This shift may be helped with legal challenges to these systems, such as the National Association for the Advancement of Colored Persons’ (NAACP’s) intention to hold states accountable for race-based inequities in public education. Concurrent with efforts to change public policy, robust partnership programs that meaningfully link health professions schools and teaching hospitals with local schools and communities are also needed to strengthen the education pipeline. Progressive programs aimed at elementary, high school, and college students illustrate the payback of investing in the early education of our nation’s youth. Examples include the Department of Health and Human Services’ Health Careers Opportunity Program (HCOP) and Centers of Excellence, the previously mentioned HPPI program, and the Minority Medical Education Program (MMEP), a summer enrichment program funded by the RWJF and administered by the AAMC.
In the interim, as changes to the education pipeline take hold, the best means available for closing the diversity gap is to use affirmative, race-conscious decision making in higher education in general and in medical and other health professions schools in particular. The Supreme Court’s 1978 decision in Bakke, which still holds in the great majority of jurisdictions, offers the legal basis for using race and ethnicity as one factor among a host of others in selecting applicants from a common pool to achieve a diverse cohort of matriculants. It is noteworthy that the University of Michigan has thus far been successful in defending its race-conscious admissions policies in the courts.\footnote{19}

Opponents of affirmative action in medical schools’ admissions policies frequently raise the concern that by using this tool, and thereby increasing the number of minority students, unqualified persons are allowed to become doctors. The data clearly belie this concern. Given the numerous academic hurdles that must be cleared in medical school, in residency training, and in acquiring a license, the chances that an unqualified person will make it into practice are exceedingly small. Indeed, policymakers and the public at large should take great comfort from the remarkable success that medical school admissions committees have had in using affirmative action in accordance with the mandates of Bakke.

Admissions committees have become very adept at identifying students in the applicant pool who, despite challenges resulting from often inferior academic preparation, manifest the character, intelligence, and drive to master the demanding medical school curriculum and succeed as physicians and medical scientists. That only a handful of students from all backgrounds, majority and minority alike, prove unable to withstand the rigors—or meet the financial costs—of a medical education and thus must abandon the quest along the line, is ample testimony to these committees’ skill and wisdom.

Increasing the racial and ethnic diversity of the health care workforce has several predictable consequences, all of which are salutary. To provide optimal care to an increasingly diverse population, all health care professionals must become culturally competent practitioners. Future physicians, physician assistants, nurses, pharmacists, and dentists can acquire the necessary attributes to fulfill this obligation only by being educated in the company of a broadly diverse student body and in learning environments that reflect the diverse society they will be called upon to serve.

Moreover, expanding the number of minority physicians in the health care workforce will likely improve access to high-quality health care for underserved populations because such physicians, to a disproportionate extent, choose to practice in HPSAs and to serve the needs of minority patients. In addition, increasing the number of minority physicians and scientists who select careers in medical research would, in all likelihood, result in a broadening of the research agenda to encompass a greater emphasis on problems of particular importance to
improving the health of minority populations and reducing health disparities. Finally, increasing the cadre of minority health professionals interested in assuming management and policy-making roles in the future health care system would help ensure that tactical and strategic decisions about matters such as resource allocation and program design are tailored to the needs of a diverse society.

These practical arguments for increasing diversity in the health care workforce leave unexpressed an additional argument of a more philosophical nature. The health professions occupy a lofty status in American society and offer those who enter them many of the most challenging and rewarding career opportunities available anywhere. By reaching out to students underrepresented in the health care workforce and those who, through no fault of their own, have been deprived of an excellent preprofessional education but who possess all of the qualities of mind and spirit required to excel as health professionals, health professions schools not only achieve the diversity needed for high-quality education, but also help to fulfill the American ideals of fairness, justice, and equity.

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NOTES
2. Ibid.


18. Ibid.

19. Ibid.

20. Ibid., 61.


22. Ibid., 61.


25. Ibid., 34.


29. Ibid.


33. Ibid., 135.

34. AAMC, AAMC Data Book, 21.


36. Ibid.

