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# The Case For Diversity In The Health Care Workforce

Interventions to improve the racial and ethnic diversity of the U.S. medical workforce should begin well before medical school.

by **Jordan J. Cohen, Barbara A. Gabriel, and Charles Terrell**

**PROLOGUE:** The notion that substantial improvements in the health indicators of U.S. racial and ethnic minority populations have been achieved over the past fifty years is relatively uncontroversial. By way of example, David Mechanic recently reported in *Health Affairs* (Mar/Apr 02) that infant mortality among African Americans fell from 43.9 deaths per thousand in 1950 to 13.8 in 1998. However, as Mechanic also noted, the troubling fact that infant mortality among African Americans remained 130 percent higher than that among whites as recently as 1998 dramatically illustrates that despite improvements in absolute numbers, the issue of health disparities is an independent question that retains much contemporary salience.

The popular media have widely reported the results of recent studies finding that even when insurance status, income, age, and severity of condition have been adjusted for, minorities tend to receive lower quality of care than whites do. The emergence of something approaching a critical mass of evidence documenting these inequities may be driving a fundamental shift in the discourse on minority health from inquiries into whether disparities do, in fact, exist to discussions of strategies aimed at diminishing or eliminating them. Among such proposed solutions are efforts crafted to boost minority representation in the health care workforce.

In the paper that follows, Jordan Cohen, Barbara Gabriel, and Charles Terrell argue that given changing U.S. demographic trends, achieving greater diversity in the health care workforce will likely yield the practical benefits of producing a culturally competent workforce, improving access to high-quality care for the medically underserved, increasing the breadth and depth of the U.S. health research agenda, and expanding the pool of medically trained executives and policymakers ready to take up leadership positions in the health care system of the future. The authors also evaluate the efficacy of past efforts to improve minority representation in medicine and provide insight into future approaches targeted at bridging the diversity gap. Cohen is president of the Association of American Medical Colleges (AAMC). Gabriel is the senior writer and editor for the AAMC, and Terrell is vice-president of the AAMC's Division of Community and Minority Programs.

**ABSTRACT:** Increasing the racial and ethnic diversity of the health care workforce is essential for the adequate provision of culturally competent care to our nation's burgeoning minority communities. A diverse health care workforce will help to expand health care access for the underserved, foster research in neglected areas of societal need, and enrich the pool of managers and policymakers to meet the needs of a diverse populace. The long-term solution to achieving adequate diversity in the health professions depends upon fundamental reforms of our country's precollege education system. Until these reforms occur, affirmative action tools in health professions schools are critical to achieving a diverse health care workforce.

WERE THE UNITED STATES NOT A COUNTRY with a rich variety of races and ethnicities, let alone one that is rapidly becoming more diverse, the case for diversity in the health care workforce would arguably be moot. But the facts are clear: Our country is undeniably becoming home to an ever-increasing number of individuals from distinct racial and ethnic backgrounds. Census figures vividly document that our minority populations are increasing at a much faster pace than is the majority white population. Between 1980 and 2000, while the country's white population grew by about 9 percent, the African American population increased by about 28 percent; the Native American population, by 55 percent; the Hispanic population, by 122 percent; and the Asian population, by more than 190 percent.<sup>1</sup> As a result, somewhere near the middle of this century more than half of U.S. citizens will be members of "minority" groups.<sup>2</sup> Figures from the 2000 census show that African Americans, Hispanics, Asians, and Native Americans already account for more than half of California's population. Forty-five percent of Texans self-identify as members of minority groups, as do one in three residents of New York, New Jersey, and Florida.<sup>3</sup>

Recognizing these striking demographic trends does not in itself establish the case for diversity in the health professions. To do that would require convincing arguments that absent sufficient ethnic and racial diversity, the health care workforce would be unable to fulfill its fundamental obligations to the public: protecting, restoring, and improving the health of all Americans. The following discussion summarizes the arguments favoring greater diversity in the health care workforce, reviews results of previous efforts to increase the proportion of minorities in medicine, and considers the prospects for future progress in closing the still sizable diversity gap.

### The Case For A Diverse Health Care Workforce

Putting aside issues of equity and fairness for the moment, at least four practical reasons can be put forth for attaining greater diversity in the health care workforce: (1) advancing cultural competency, (2) increasing access to high-quality health care services, (3) strengthening the medical research agenda, and (4) ensuring optimal management of the health care system. Although the focus of this paper is on the M.D. workforce, there is every reason to suspect that these ar-

guments apply equally well to the other health professions (osteopathy, dentistry, public health, nursing, pharmacy), which have also experienced difficulty in recruiting persons from minority backgrounds in adequate numbers to achieve optimal diversity. The recruitment of these persons into the educational pipeline of the health professions is, of course, what determines not only their ultimate representation in the workforce but also their influence on the educational process itself.

■ **Culturally competent workforce.** This brings us to the first and perhaps most compelling reason for increasing the proportion of medical students and other prospective health care professionals who are drawn from underrepresented minority groups: preparing a culturally competent health care workforce. The term *cultural competence* denotes the knowledge, skills, attitudes, and behavior required of a practitioner to provide optimal health care services to persons from a wide range of cultural and ethnic backgrounds. Given the rapidly changing U.S. demography, it is axiomatic that the majority of future health care professionals will be called upon to care for many patients with backgrounds far different from their own. To do so effectively, health care providers must have a firm understanding of how and why different belief systems, cultural biases, ethnic origins, family structures, and a host of other culturally determined factors influence the manner in which people experience illness, adhere to medical advice, and respond to treatment. Such differences are real and translate into real differences in the outcomes of care. Physicians and other health care professionals who are unmindful of the potential impact of language barriers, various religious taboos, unconventional explanatory models of disease, or traditional “alternative” remedies are not only unlikely to satisfy their patients but, more importantly, are also unlikely to provide their patients with optimally effective care.

Health care professionals cannot become culturally competent solely by reading textbooks and listening to lectures. They must be educated in environments that are emblematic of the diverse society they will be called upon to serve. The logic here is analogous to that upholding the value of diversity in all aspects of higher education. Consider the views of Lee Bollinger, president of Columbia University. He asserts that racial and ethnic diversity in the educational setting is paramount to a student’s ability to effectively live and work in a diverse society.<sup>4</sup> A series of empirical analyses of existing data on diversity in higher education support Bollinger’s assertion.<sup>5</sup> Presented in an expert report used in the lawsuits challenging the University of Michigan’s undergraduate and law school admissions policies, these analyses “confirm that racial diversity and student involvement in activities related to diversity had a direct and strong effect on learning and the way students conduct themselves in later life, including disrupting prevailing patterns of racial separation.”<sup>6</sup>

Only by encountering and interacting with individuals from a variety of racial and ethnic backgrounds can students transcend their own viewpoints and see them through the eyes of others. A heterogeneous campus helps students to recog-

*“Stagnation in minority representation in the physician workforce will have unwelcome consequences for the health of the nation.”*

nize that their own opinions are influenced by their unique race, gender, origin, and socioeconomic status. Coupled with the additional need of medical students to become culturally competent practitioners, these overarching principles for achieving good-quality higher education constitute the first of several compelling arguments for diversity in our nation’s medical schools.

■ **Access for the underserved.** A second reason for favoring greater diversity in medical education, and hence in the physician workforce, is to provide improved access to high-quality health care for persons in our society who remain underserved. Inadequate access to health care services remains a major problem within minority populations. Many of the country’s designated health professions shortage areas (HPSAs) are populated predominantly by minorities.<sup>7</sup> In California, physician supply has been shown to be inversely related to the number of resident African Americans and Hispanics, even after income levels are adjusted for.<sup>8</sup> Members of minority groups who do gain access are likely to receive lower-quality care, even when insurance status and income are controlled for.<sup>9</sup> For example, studies indicate that African Americans and Hispanics are less likely to receive bypass surgery when medically indicated, are less likely to receive adequate pain management, and are less likely to be treated with medications for HIV infection.<sup>10</sup> Minorities are also more likely to undergo procedures such as bilateral orchiectomy (removal of the testicles) and amputation, which are generally avoidable with optimal medical care.<sup>11</sup>

Abundant data now exist documenting that African American, Hispanic, and Native American physicians are much more likely than white physicians are to practice in underserved communities and to treat larger numbers of minority patients, irrespective of income.<sup>12</sup> Moreover, African American and Hispanic physicians, as well as women, are more likely to provide care to the poor and to those on Medicaid.<sup>13</sup> Evidence also suggests that racial and ethnic concordance between physician and patient results in greater patient satisfaction.<sup>14</sup> Furthermore, racial and ethnic concordance is not exclusively the result of physician practice location; it also appears to be a result of patient choice.<sup>15</sup>

None of these data should be misconstrued to suggest either that minority physicians have an obligation to serve minority populations or that white physicians do not contribute much to the care of the underserved. These and similar data serve merely to substantiate the current reality that physicians from minority backgrounds are more likely to choose to practice in underserved areas than are other physicians and that patients are more satisfied with the services rendered by physicians of their own racial or ethnic heritage. Thus, it is reasonable to conclude that greater racial and ethnic diversity in the physician workforce would serve to reduce the gap in access to care that characterizes America’s health care system.

Conversely, in light of changing U.S. demographics, stagnation or reduction in minority representation within the physician workforce will, in all probability, have unwelcome consequences for the health of the nation.

Racial and ethnic disparities in health and health care services are well documented, and their eradication is one of the prime targets of Healthy People 2010.<sup>16</sup> African Americans have a lower life expectancy than whites; they are more likely to die from stroke, cancer, and diabetes mellitus.<sup>17</sup> Infant mortality rates are higher among African American and Native American populations.<sup>18</sup> African Americans, Hispanics, and Native Americans have higher rates of HIV infection than whites do and are more likely to die from homicide.<sup>19</sup> Population-specific studies across the nation have found that African Americans are also more likely to suffer from uncontrolled hypertension, leading to more coronary heart disease-related events.<sup>20</sup> A Chicago study indicated that African American women are twice as likely to die from cervical cancer than white women are, and a national study found that African Americans are at an increased risk of dying from asthma complications, even after income and education levels are controlled for.<sup>21</sup>

Differences in racial and ethnic background, socioeconomic status, environment, and other risk factors notwithstanding, researchers agree that many of these negative health outcomes are preventable with appropriate outpatient management.<sup>22</sup> Evidence also points to biases on the part of health care providers and institutions as greatly contributing to unequal medical treatment.<sup>23</sup> Without adequate access to diverse and culturally competent health care providers drawn from all sectors of society, it is difficult to imagine how America can eradicate these and other health disparities.

■ **Broadened research agenda.** A third reason for advocating greater diversity in medicine is to broaden and strengthen the U.S. health research agenda. As just noted, the United States is plagued by unsolved health problems, many of which disproportionately affect minority populations. Few would argue that we have sufficient understanding of these problems to craft appropriate solutions. A great deal of additional research—particularly clinical and health services research—is clearly needed. Why has the necessary research not been done already? One explanation is that the U.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, what excites their curiosity, depends to a great extent on their personal cultural and ethnic filters. Thus, it is reasonable to conclude 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 and ethnically (as well as by gender) than we now have. Creating that workforce begins with ensuring a diverse student body, as well as faculty, within U.S. health professions schools, particularly in M.D., Ph.D., and M.P.H. programs.

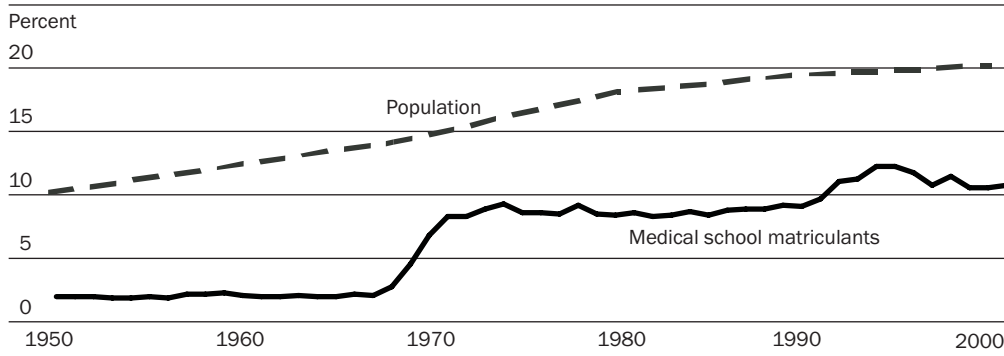
The extent to which the needed research will require the adequate participa-

tion of individuals from minority populations constitutes yet another argument for a more diverse cadre of investigators. As a case in point, a recent study of the attitudes of African Americans toward participation in cancer-related clinical trials found considerable distrust of government-backed medical research, with African American men citing the Tuskegee syphilis experiment as their principal source of concern.<sup>24</sup> Study participants also expressed a preference for health care providers and researchers who “looked like them,” an attitude that was found to be an important factor in their willingness to participate in clinical trials.<sup>25</sup>

■ **Diversity in related workforces.** A fourth reason for seeking greater diversity in education in the health care professions is to augment the pool of medically trained executives and public policymakers available to assume management roles in the future health care system and to contribute to governmental efforts that address important health care issues. Providing appropriate health care services to an ever-more diverse population is bound to pose an increasingly difficult management challenge for provider organizations; health care funders; public and private program managers; and local, state, and national governments. Within the private sector, it seems self-evident that having a comparably diverse management team—including key members with medical training—to make crucial strategic and tactical decisions would be, at minimum, advantageous and in many cases decisive for success. As is the case for virtually all sectors of the U.S. economy, it is simply smart business for health care organizations to draw their leadership from a richly diverse talent pool, adequately reflecting the gender, racial, and ethnic mélange of the country. Likewise, medically trained health care policymakers who more accurately reflect the face of the American public can have a substantial influence on the future of health care policy for all Americans. The paucity of such individuals in the current health professions workforce and influential policy-making posts constitutes yet another barrier to achieving high-quality health care for all Americans. Indeed, the lack of minorities from the ranks of medical management and public policy roles reflects the long heritage of underrepresentation of minorities in the health care workforce in general.

### Historical Efforts To Increase Diversity In Medicine

Prior to the late 1960s, the racial (and gender) composition of medical school classes, and hence of the medical profession in this country, was monotonously white (and male). Despite a progressively expanding presence in our population, groups now designated as underrepresented minorities (African Americans, Mexican Americans, Native Americans, and mainland Puerto Ricans) made up only about 2 percent of medical school matriculants (Exhibit 1), and three-quarters of those attended either Howard University College of Medicine or Meharry Medical College School of Medicine as late as the mid-1960s. The typical medical school of that era admitted, on average, one minority student every other year. Racial segregation was as fully evident in medicine as it was in virtually every other

**EXHIBIT 1****Percentage Of Underrepresented Minorities Among Medical School Matriculants And In The U.S. Population, 1950–2001**

**SOURCES:** Association of American Medical Colleges, *Minority Graduates of U.S. Medical Schools: Trends, 1950–1998* (Washington: AAMC, 2000), 25; AAMC, *AAMC Data Book: Statistical Information Related to Medical Schools and Teaching Hospitals* (Washington: AAMC, January 2001), 21; U.S. Census Bureau, Population Division, “Race and Hispanic Origin of the Population by Nativity: 1850 to 1990,” Table 8, [www.census.gov/population/www/documentation/twps0029/tab08.html](http://www.census.gov/population/www/documentation/twps0029/tab08.html) (3 June 2002); and U.S. Census Bureau, Population Estimates Program, Population Division, “Resident Population Estimates of the United States by Sex, Race, and Hispanic Origin: April 1, 1990 to July 1, 1999, with Short-Term Projection to November 1, 2000,” [eire.census.gov/popest/archives/national/nation3/intfile3-1.txt](http://eire.census.gov/popest/archives/national/nation3/intfile3-1.txt) (3 June 2002).

**NOTE:** For this comparison, “underrepresented minorities” are African Americans, Mexican Americans, Native Americans, and mainland Puerto Ricans.

sector of American society, just as it had been for many preceding decades.

Things began to change with the advent of the civil rights movement in the late 1960s. The subsequent assassination of Martin Luther King Jr. and a rash of urban riots woke many people up to the flagrantly discriminatory practices that characterized so much of American society. The institution of medical education was inextricably influenced by the gains of minorities in other professions made possible by the breaking down of barriers to their professional advancement. Trends in medical school enrollment during this turbulent period in U.S. history were accordingly influenced by the tremendous societal changes brought about by the efforts of civil rights pioneers and activists.

The result was a striking rise in the number of minority medical students. What changed was not a dramatic rise in academic achievement among minority applicants, as measured by such yardsticks as test scores and grade-point averages. Rather, what led to this upsurge was the commitment by schools across the country to take a closer look at barriers to access and consider affirmative actions to increase the racial and ethnic diversity of their classes. The federal government also played a key role by establishing financial aid and other programs for socio-economically disadvantaged and minority students.

These programs continue to serve the interests of diversity today. However, a number are under threat of reduced funding, including an array of programs authorized by Titles VII and VIII of the Public Health Service Act. These programs support financial aid to health professions students, offer enrichment and training



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.<sup>26</sup> 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.<sup>27</sup> Project 3000 by 2000 was designed to help remedy this root cause of minority underrepresentation in medical schools.<sup>28</sup> 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.<sup>29</sup> 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."<sup>30</sup> 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.<sup>31</sup>

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.<sup>32</sup> 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.<sup>33</sup>

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.<sup>34</sup> 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 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.<sup>35</sup> 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.<sup>36</sup> 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.<sup>37</sup> 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.<sup>38</sup> 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.<sup>39</sup>

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.

**I**NCREASING 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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*The authors acknowledge Ruth Beer Bletzinger, director of the Association of American Medical Colleges (AAMC) Division of Community and Minority Programs, for her invaluable research assistance.*

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