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CLINICAL CASE
Should Applicants' Ethnicity Be Considered in Medical School Admissions?
Commentary by Will Ross, MD, MPH

The medical school admissions committee was assembled for a meeting, and the first file on the table was Daniel's. After the committee took some time to look over Daniel's file, Dr. Monroe, an older physician and long-standing member of the admissions committee, began the discussion.

"Daniel seems like the ideal candidate to accept into our entering class. His strong MCAT score and GPA, effusive letters of recommendation, and record of leadership and service all indicate that he will thrive at our institution."

Dr. Spence, another member of the admissions committee, added, "I interviewed Daniel and was quite impressed with him. In addition to his remarkable qualifications, I believe that Daniel's fluency in Spanish and his Latino heritage are key assets, especially for communicating with our hospital's patient population."

A number of the members of the admissions committee voiced their agreement, but Dr. Monroe was silent on this point. After a short period of deliberation, Daniel received a unanimous vote of admission, but after the vote was cast Dr. Monroe raised his hand.

"I have a point of concern that I would like to raise up before we go forward with our discussions of the other candidates."

The members of the committee turned to him.

"I may be alone in this, but I am bothered that Daniel's ethnicity was brought up in our discussion. Unfortunately this is not an isolated occurrence but rather an increasingly regular one when we are discussing applicants from underrepresented minority groups. I wanted to assess where our committee stands with regard to using a candidate's ethnic background as a qualification for admission."

He continued, "Yes, in this case Daniel was an excellent candidate and would have been accepted on his credentials alone, but what will we do in the cases in which an applicant from an underrepresented minority group has less impressive qualifications? How much of an advantage would we allow ethnicity or minority status to play in those circumstances? I believe that our sole job as an admissions committee is to admit the most-qualified students, those who will go on to make the best doctors, regardless of their ethnicity."

Dr. Spence interjected, "But don't we also have a duty to the immediate community in which we serve to make sure that the health needs of all of our patients are being met? Our ability to care for patients in part depends on their willingness to confide in us. Many of our hospital's patients are Spanish-speaking, and many of them are more comfortable speaking with a student or doctor who shares their background. If there is miscommunication between a patient and a doctor due to language barriers or cultural issues, then even the best doctor, according to your standards, would not be able to provide that patient with the best care."

"Then where do you draw the line?" asked Dr. Monroe. "I worry that we might be standing on a slippery slope."

Commentary

I have had many conversations about racial and ethnic diversity with members of the admissions committee at my institution, and I always respond that "context matters." I will present my contextually laced argument, relying heavily on the role of beneficence—doing the right thing, as it relates to medical school admissions, patients, and society. According to a 2001 Institute of Medicine study, diversifying the health professions is both the "right thing to do and the smart thing to do" [1]. It is the right thing to do from the standpoint of social justice—African Americans, American Indians, and Hispanics make up approximately 25 percent of the U.S. population but account for only 6 percent of practicing physicians. Such a statistic is unconscionable in a country plagued by almost intractable disparities in health status between members of majority and minority groups [2]. It is the smart thing to do for four essential reasons, as outlined by Jordan Cohen, former president of the Association of American Medical Colleges [3]:

1. High-quality medical education is further enhanced by adequate representation among students and faculty of the diversity of the U.S. society.
2. Increasing workforce diversity will improve access to care for underserved population.
3. Increasing the diversity of the research workforce can accelerate advances in medical and public health research.
4. Diversity among managers of health care organizations makes good business sense.

But does the desirability of having a diversified workforce in medicine create a duty for medical school admissions committees to select students from underrepresented minority groups? Achieving the egalitarian goal of increased diversity in medical schools has its daunting challenges; while the actual numbers of students from underrepresented groups in medicine (URMs) increased from 5,205 in 2002 to 6,393 in 2007, the percentage of applicants who were URMs remained flat at 15 percent [4]. Among the reasons for the small number of candidates from URMs are the increasing attraction of nonmedical professions, the lack of financial capital and social support, poor academic readiness due to substandard public education, and

limited opportunities for networking and mentoring [4]. Medical school admissions committees, cognizant of the need for greater minority group representation in medicine, have to contend with competing for the top students in a very limited pool of candidates. The net effect of this zero-sum game is unhealthy competition among medical schools that treats students like a commodity on the open market and precludes greater collaboration. Clearly a better strategy is needed.

Is Affirmative Action Appropriate in the Context of Medical School Admissions?

Legal challenges to affirmative action have limited the use of race as a factor in the admissions process and placed further constraints on medical school admissions committees. The ruling in the 1996 Hopwood case in the U.S. Court of Appeals 5th Circuit and various referenda against affirmative action, such as the 1996 Proposition 209 in California, had a chilling effect on matriculation of students from URMs in U.S. medical schools [3]. After passage of Proposition 209 in 1996, the percentage of minority medical school California residents studying in-state declined from 23.1 percent in 1993, to 14.3 percent in 1997. Similarly, 1 year after Washington State passed the anti-affirmative action referendum 1-200 in 1998, minority enrollment dropped almost 30 percent, with an entering class of 1.84 percent African Americans, 0.91 percent American Indians, and 2.9 percent Hispanics.

The 2003 U.S. Supreme Court ruling on the University of Michigan case, *Grutter v. Bollinger*, disavowed the use of race-based admissions policies that were not narrowly tailored, while affirming the *Bakke* opinion that "student body diversity is a compelling state interest" and that race and ethnicity could be considered among "other factors" in deciding admissions [5]. Writing for the majority, Justice O'Connor stated:

> In order to cultivate a set of leaders with legitimacy in the eyes of the citizenry, it is necessary that the path to leadership be visibly open to talented and qualified individuals of every race and ethnicity. All members of our heterogeneous society must have confidence in the openness and integrity of the educational institutions that provide this training [6].

Many admissions committees at the more selective medical schools, as well as state schools in more conservative districts, still rely heavily on traditionally quantitative measures of admissibility such as the Medical College Admissions Tests (MCAT) and undergraduate GPAs. Applicants from groups underrepresented in medicine tend to have lower GPAs and MCAT scores than non-Hispanic white applicants, but there is disagreement about the significance and impact of those differences [7]. A meta-analysis of the predictive value of MCAT on medical school performance indicated only a small to medium effect with a predictive validity coefficient of $r = 0.39$ [8]. Cohen noted that in 1990, students from URMs had a graduation rate of 90 percent compared to a graduation rate of 96 percent for white students [3]. The high graduation rate for the former group validated the ability of medical school admissions committees to identify students who were committed to achieving and exceeding the high academic standards of medical schools. From an evidence-based

standpoint, traditional criteria such as MCAT and GPA do not adequately predict medical school performance and should be considered along with other humanistic, nonquantitative variables in selecting the most qualified student to practice medicine.

What Are the Benefits of Ethnic Concordance Between Patient and Doctor?
Affirmative action in medical school admissions is the right thing to do from the perspective of the patient and society. Traditionally, underrepresented groups in medicine (African Americans, Native Americans, and Hispanics) suffer a disproportionate burden of mortality and disability from preventable illness and disease. They are more likely to be uninsured or underinsured and live in communities with limited access to primary care physicians. According to the 2002 Institute of Medicine Report, "Unequal Treatment," disparities in health status persist even after controlling for income status and educational attainment [9]. Consequently, apart from addressing health inequities to ameliorate the adverse economic impact on the country, society has a moral imperative to improve the health of underserved communities by providing access to culturally relevant health care and increasing the diversity of the health care workforce. Kenneth Ludmerer, author of *Time to Heal*, was visionary and forthright in his statement: "The key [to retaining U.S. leadership in medicine] lies in restoring the tattered social contract between medicine and society" [10].

That social contract acknowledges the considerable benefit gained by promoting diversity in the health care workforce. Cantor et al. found that physicians from underrepresented groups were more likely to care for medically underserved groups, including poor and Medicaid patients, than were white physicians [11]. Moy et al. noted that, among patients who reported having a physician as their usual source of care, minority patients were more than four times more likely to report receiving care from minority physicians than were white patients [12]. In a survey of California physicians, Komaromy et al. found significant racial and ethnic concordance between physicians and their patient populations [13]. After controlling for the racial and ethnic makeup of the community, she found that black physicians cared for significantly more black patients and Hispanic physicians, for significantly more Hispanic patients than did other physicians.

Furthermore, efforts to diversify the medical workforce will also expand the practice of culturally and linguistically concordant health care. Increasing culturally sensitive health care can result in enhanced patient-clinician communication, improved patient education efforts, and better health care outcomes stemming from appropriate modification of health behaviors. Citing the limited racial and linguistic concordance between physicians and patients in minority populations, Saha and colleagues found that African American respondents to a 1994 Commonwealth Fund Health Survey were more likely to report receiving preventive care—and all had needed medical care during the previous year if they had an African American physician—compared to those with non-African American physicians [14]. Hispanics with Hispanic physicians were also more likely to be very satisfied with their overall health care compared to those with non-Hispanic physicians. Additional studies are ongoing to

correlate race and linguistic concordance with improved health outcomes and reduction of health disparities.

What Can Medical Schools Do?

Medical school admissions committees typically utter a sigh of relief when they come across an applicant group from a URM whose academic credentials approximate those of the applicants from majority groups. They may have reservations, however, about accepting such candidates with lower credentials, thinking that that student will feel stigmatized as a medical student and underperform based on what Claude Steele calls "stereotype threat" [15]. Committee members can be reassured that, by adopting a more holistic approach to admissions decisions that factors in humanistic attributes such as realistic self-appraisal, leadership, interpersonal skills, presence of social support, compassion, and service along with variables in the cognitive domain such as MCAT and GPA, they are more likely to accept a student eager to meet the health needs of a diverse society [16]. Such students are also more likely to engage in research that can be translated into improved clinical outcomes for the immediate and international community. Medical schools and their admissions committees would be remiss if they did not seek a broader role in expanding the pipeline to students and faculty from URM groups and promoting cultural transformation of medical centers, while engaging students, trainees, and faculty in service learning, neighborhood-based health care, and population-based research.

Conclusion

Ultimately, fulfilling the social contract between medicine and society does not and cannot rest solely on the limited number of students from groups underrepresented in medicine. It is a collective responsibility of the profession, and our inability to act reflects an unacceptable moral failure. There are encouraging signs that medical students from all backgrounds are accepting the charge. Saha and colleagues found, for example, that, after adjusting for various school and student characteristics, increased medical school diversity is associated with white students feeling better prepared to care for diverse patients [17]. This bodes well for curricula that emphasize cross-cultural medical education. Medical school admissions committees can act within current legal guidelines in identifying and recruiting students of color while promoting the benefits of diversity on their campuses. Such an approach, operating through beneficence, allows us to fulfill medicine's obligation to society—our schools will be the better for the effort.

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