

The State of Diversity in the Health Professions a Century After Flexner

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Abstract

Although the 1910 Flexner Report recommended the closure of a large number of operating medical schools, its impact was disproportionately felt on minority schools. The report's recommendations resulted in the closure of five out of seven predominantly black medical schools. Also noteworthy about the report was Flexner's utilitarian argument that black physicians should serve as sanitarians and hygienists for black communities in villages and plantations.

A century later, despite decades of targeted programs and advocacy, minorities are still vastly

underrepresented among medical students, physicians, and medical school faculty of all ranks. Today's arguments about the need for diversity in medicine in many ways echo Flexner's words. They continue to focus on benefits to minority populations, service in underserved areas, and minorities' role in the primary care workforce. These are valid, in fact laudable aspirations, but when made in isolation, they circumscribe the value of minority medical professionals. Minorities in the medical sciences provide immeasurable services to the entire nation, enhancing educational outcomes, expanding and improving the quality of health care provided, and contributing to

the breadth and depth of medical research.

This article presents how the Flexner Report shaped medical education and created a culture of medical research leading to narrow performance standards that fail to properly reward teaching activities, patient care, and health promotion. Efforts to achieve diversity in medical education should not end at graduation but should be extended to provide minorities opportunities to excel and to lead.

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Abraham Flexner's Carnegie Foundation *Bulletin No. 4* was published in 1910, against a backdrop of a nation in the midst of the "Progressive Era," striving to emerge as a world superpower.¹ Amid these aspirations, women were demanding equality, and workers were seeking safer and more equitable working conditions. This period was also one of contentious race relations. Discrimination against blacks permeated every facet of social and economic life, unhindered by government authorities.

Against this backdrop of social unrest, Flexner's report recommended changes to the landscape of U.S. medical education that disproportionately

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affected minority medical schools. Here, we examine the state of diversity in medical education since the report was published 100 years ago, predominantly focusing on historically black colleges and universities (HBCUs) because of the direct impact Flexner's report had on these institutions. We recognize that issues of inclusiveness and diversity encompass more than race and ethnicity. Disparities can exist because of gender, socioeconomic factors, disability status, and age, among other issues. However, we focus our discussion on racial and ethnic groups that have traditionally been underrepresented in the health professions. These include African Americans, Hispanic Americans, Native Americans, Alaskan natives, Native Hawaiians and other Pacific Islanders, and certain Asian subgroups (Vietnamese, Hmong, and Cambodian).

The Backdrop: Then and Now

In 1910, the U.S. population was majority white. Blacks were 10.6% of the population and constituted by far the largest racial minority. American Indians and Asian Americans together totaled less than 1% of the U.S. population.²

In 1900, life expectancy was 48.2 years for white males and 51.1 years for white

females.¹ Segregation, discrimination, poverty, inadequate medical facilities and medical personnel, poor housing, and malnutrition all wreaked havoc on the health of black communities. The average life expectancy for blacks was 32.5 years for males and 35.0 years for females.¹ There were high rates of mortality from infectious diseases such as typhoid fever and tuberculosis. Moreover, inequalities in the U.S. education system in the early 20th century were prominent because of legal segregation in the South and de facto segregation in the North.

By the beginning of the 21st century, the United States had evolved into one of the most diverse nations in the world, receiving more immigrants than all other nations combined, predominantly from Asia and Latin America. Census data from 2005 show that more than a third of the U.S. population (34%) are ethnic or racial minorities, and more than 50 million Americans speak languages other than English at home, either alone or alongside English.^{3,4} Furthermore, U.S. Census projections show that there will no longer be a white majority in the United States by 2042.⁵ Diversity is especially pronounced among school-age persons. Today, minorities account for 43% of Americans under 20 years of age,

and it is projected that over the next two decades minority students will be almost 40% of the total college population.⁶

In the past 100 years, developments in the biomedical sciences have resulted in unprecedented advances in medical technology. Advances in public health and medical care have transformed mortality trends in the United States. Average life expectancy has been extended by more than 30 years, and chronic diseases, rather than infectious diseases, are now the leading causes of death.⁷ However, disparities in life expectancy, in health status, and in access to health care for ethnic and racial minorities have persisted and, in some cases, widened.⁸ In 2005, the average life expectancy of black males was 69.5 years while that of white males was 75.7 years. The 2007 National Healthcare Disparities Report (NHDR) concludes that disparities in quality and access for minority groups and poor populations have not been reduced since the first NHDR in 2003.

Flexner's Impact on Medical Education for Minorities

Flexner's report stimulated reform of medical education and led to high-quality training and professional standards that have placed the United States ahead of other nations in medical education.⁹ However, the recommendations in the Flexner Report adversely affected minority schools and graduates in three ways: (1) The report led to a drastic reduction in the number of predominantly black medical schools, (2)

it led to the development of admissions standards that rendered medical education beyond the reach of most blacks for decades, and finally, (3) it articulated a limited vision of the role of black physicians in America, thus marginalizing black schools and their graduates.

Minority-related trends in medical education since 1910

Over the course of 18 months, from 1908 to 1910, Flexner visited 155 medical schools in the United States and Canada. At each, he examined entrance requirements, faculty–student ratios, financing, library facilities, laboratory instruction, and access to teaching hospitals and clinical mentors.⁹ At the time of the Flexner Report, seven black medical schools were in operation (Table 1).¹⁰ These schools were in the South and were church-supported missionary institutions or proprietary establishments. The schools were underfunded, had limited faculty and inadequate facilities, and lacked a large patient base.¹⁰ After the publication of his 1910 report, Flexner's recommendations resulted in the closure of all but two of the schools, Howard University School of Medicine in Washington, DC, and Meharry Medical College in Nashville, Tennessee. For the next 50 years, these two schools educated three quarters of the nation's black doctors.¹ In the 1960s, following increased national awareness of injustice and unequal opportunity and spurred by the civil rights movement, U.S. medical schools started to actively recruit minority students, primarily

blacks. However, as late as 1964, five American medical schools still had not admitted any black students.¹¹ Only by 1966 were blacks admitted to all U.S. medical schools. Still, Howard and Meharry were the only predominantly black medical colleges until 1978, when Morehouse School of Medicine in Atlanta admitted its first class. Shortly thereafter, in 1981, the College of Medicine at Charles R. Drew University of Medicine and Science became the fourth predominantly black medical college, though it is not yet independently accredited and provides training in concert with the David Geffen School of Medicine at the University of California, Los Angeles.

During the 1950s and 1960s, blacks represented 10% of the total U.S. population, though they made up only 2.2% of physicians. During that period Mexican Americans, mainland Puerto Ricans, and Native Americans together constituted about 3% of the population but contributed less than 0.2% of medical school enrollees.¹¹

In 1969, with funding from the U.S. Office of Economic Opportunity, the Association of American Medical Colleges (AAMC) established its Office of Minority Affairs and spearheaded major national initiatives to increase diversity in medical education.¹² Through intense efforts and major national initiatives, underrepresented minorities' (URMs') enrollment into medical schools more than tripled by 1974, reaching 10%.^{11,12} Another increase occurred in 1995, when URMs' enrollment in medical schools

Table 1
Black Medical Schools Evaluated by Flexner, 1908–1910*

Name	Location	Dates of operation	No. of medical graduates [†]
Howard University Medical College	Washington, DC	1868–present	205
Knoxville Medical College	Knoxville, TN	1900–1910	2
Leonard Medical School Shaw University	Raleigh, NC	1882–1918	400
Louisville National Medical College	Louisville, KY	1888–1912	100
Meharry Medical College	Nashville, TN	1876–present	275
New Orleans University Medical College (Flint Medical College)	New Orleans, LA	1889–1911	116
University of West Tennessee College of Physicians and Surgeons	Jackson, TN; Memphis, TN	1900–1923	155
Total graduates			1,253

* Source: Harley EH. *J Natl Med Assoc.* 2006;98:1425–1429.

† For Howard and Meharry, the numbers represent students graduating from each school's opening through 1910.

increased to 12%, no doubt in large part as a result of the AAMC's "3000 × 2000" initiative.¹² However, since then, URM's enrollment in medical schools increased slowly to 15.1% in 2008, while their representation in the U.S. population was nearly twice as high. Overall, URM graduation from medical schools has been essentially unchanged since 1985 as can be seen in Figure 1.

Today, African Americans, Hispanic Americans, and American Indians constitute more than 30% of the U.S. population.¹³ Yet, in 2007, these groups accounted for only 8.7% of physicians, 6.9% of dentists, 9.9% of pharmacists, and 6.2% of registered nurses.¹⁴⁻¹⁷ In 2006, URMs accounted for 12% of the total number of doctor of pharmacy (PharmD) degrees conferred as first professional degrees and in 2007 the same groups accounted for 13.1% of enrollees in dental school.^{18,19} Nursing data show

higher levels of diversity in nondoctoral tracks, with URMs representing 18.2% of graduates from baccalaureate programs, 16.8% from master's programs, and 14.8% in doctoral-level training programs in 2006.²⁰

Justification for diversity in medical education: then and now

Recognizing that the "negro is a permanent factor in our nation," Flexner²¹ realized the need for black physicians and personally supported both Howard's and Meharry's medical colleges. However, in a segregated society, and in an era during which racial inferiority was widely considered fact, Flexner framed the practice of the black physician as "limited to his own race." He argued that black medical graduates should view their diplomas as a commission to serve their people with humility and devotion, and should leave

the big cities for villages and plantations. Viewing blacks as a "source of infection and contagion," Flexner feared that blacks living alongside whites could communicate infectious agents such as hookworm and tuberculosis to their white neighbors. His vision for the extent of practice of the black doctor involved not research, nor academic leadership, but, instead, the task of maintaining the principles of hygiene, sanitation, and civilization "rather than surgery." This, in turn, he projected, would decrease infectious diseases among blacks and therefore limit the spread of these diseases to the white population.²¹

Today's commonly cited arguments supporting diversity in the health workforce are similarly circumscribed. The modern rationale for diversity typically focuses on those benefits realized by minorities through enhancement of patient-provider interactions, cultural sensitivity, and linguistic capability of the workforce and through specialty choices and practice locations of minority providers.²² The only area in which diversity is suggested as beneficial to persons from *all races* is the argument that the intellectual, cultural, and civic development of all students are enhanced by learning in an ethnically and racially diverse educational environment.²³

We wish to strongly emphasize that the data on the benefits of a diverse health workforce to the health care and health status of minorities are compelling and indisputable. A diverse health workforce is indeed essential for the delivery of high-quality, equitable health care to all Americans and for the elimination of health disparities. However, we seek to expand the dialogue on the case for diversity and call attention to its broader scope of benefits.

One chief argument for diversity in the health professions addresses the value of race-concordance in the medical encounter. It has been shown that patients' trust and satisfaction increase when their providers are of similar racial/ethnic and linguistic backgrounds. In such patient-physician encounters, the patient better understands the interaction and is more likely to comply with treatment regimens.²⁴ It has also been shown that minority patients at times prefer to be served by physicians of their

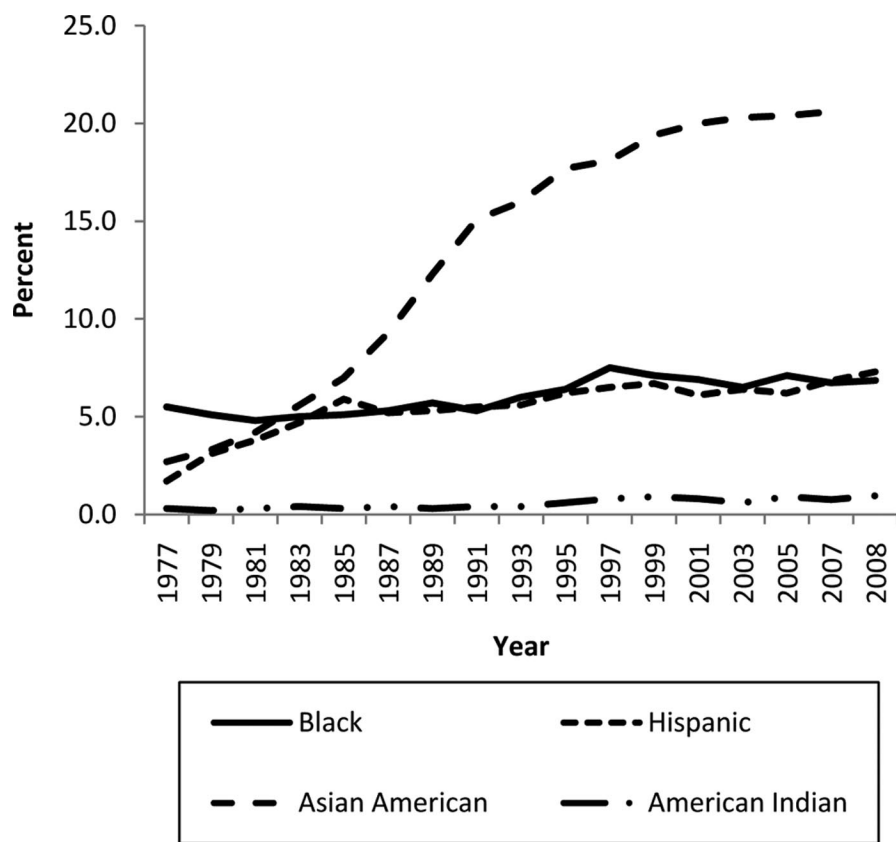


Figure 1 Minority graduation trends in U.S. medical schools, 1977 to 2008, as reported by the Association of American Medical Colleges (AAMC). * Native Hawaiians were reported as a single Pacific Islander group after the 2000–2001 academic year. Since 2000–2001, the AAMC reported "Puerto Rican" without differentiating between Mainland and Commonwealth. Since 2002, race and ethnicity could be reported alone or in combination with some other races. Data sources have changed throughout the years and may not be directly comparable between years.

* Source: Association of American Medical Colleges. Diversity in Medical Education Facts & Figures 2008, Table 8. Washington, DC, 2008.

own racial and ethnic background.^{25,26} Although this is worth noting, it is also important to recognize that there is significant heterogeneity within “racial” categories, related to ethnicity, language, dialects, religion, cultural practices, socioeconomic status, and other factors.

Another common argument for increasing diversity in the health professions relates to serving populations in Health Professionals Shortage Areas where the number of health professionals is inadequate for population size. There are abundant data showing that African American, Hispanic American, and Native American physicians are far more likely than their white counterparts to practice in underserved communities and provide service irrespective of patients’ incomes.¹⁶ In fact, minorities often choose to serve vulnerable communities.²⁶

Another argument used for diversifying medical education is that minority physicians are more likely to choose primary care specialties, an area with major public health ramifications.²⁷ Although it is evident that minority physicians are more likely to become primary care professionals, this should not be the major rationale for diversifying the health professions.

In their reviews of diversity in the health professions, Grumbach and Mendoza¹⁶ and Cohen et al²² state that although the utilitarian argument for increasing diversity is based on a substantial body of evidence, it should not be misconstrued to suggest that minority physicians have an obligation to serve vulnerable communities. Such, they say, will limit minority health professionals’ role to that of a public service and will absolve nonminority professionals of the collective responsibility of eliminating health disparities. Instead, the universal benefits of increased diversity among health professionals should be recognized.

One such benefit is that, as some have argued, diverse teams perform better. For example, Page²⁸ articulates a model in which diversity improves overall performance of teams and institutions. Page’s model shows that identity diversity leads to cognitive diversity, which improves the problem-solving capacity and creativity of teams, from corporate America to the workforce and the

research environment. Differences in life experiences, perceptions and practices shape the thinking of an individual, and it is these differences, Page argues, that “provide the seeds of innovation, progress, and understanding.”²⁸ Similarly, Cohen et al²² make the case that investigators in medical research envision research questions on the basis of their life experiences. Broadening the investigators’ pool, they contend, can lead to solutions to previously unsolved medical problems.

Lastly, increased demand for health services and the upcoming retirement of the baby boomer generation are contributing to a critical health workforce shortage. The PricewaterhouseCoopers Health Research Institute predicts a shortage of 24,000 physicians by 2020. This expectation has led to a call by the AAMC for a 30% increase in medical school enrollment and an expansion of graduate medical education positions by the year 2015.^{29,30} With the growing representation of minorities among school-aged children and the projection that during the next two decades minority student enrollment in college will reach nearly 40%,⁶ increasing physician supply and increasing diversity in the health professions are essentially the same goals.

The culture of medical research after Flexner

Flexner’s evaluation of medical schools came on the heels of a medical discovery movement which viewed experimental medicine using basic sciences as pivotal to understanding the basic causes and treatment of human disease.³¹ It was at this time that laboratory research flourished in Europe and the United States, and formal analytical reasoning became an integral component of natural sciences. These standards and the ideal of bench-to-bedside medicine set a new paradigm for medical education in the 20th century. Medical schools became heavily reliant on evidence-based knowledge in their teachings. This value system transformed medical education and strengthened the research environment in medical education. However, in some academic hospitals, teaching and patient care may be less valued when a research culture of “publish or perish” exists.

Minorities in academic medicine: Missing mentors

A shortage of minority faculty to serve as mentors and pathfinders for minority students is considered one of the major institutional challenges in recruiting URM students.³² Although there have been a number of reports about the need to diversify academic faculty,¹³ during the 2007–2008 academic year, URMs made up only 7.4% of U.S. medical school faculty, less than 7% of undergraduate faculty, less than 10% of baccalaureate and graduate nursing school faculty, 12% of clinical psychology faculty,* and 8.6% of dental school faculty.^{33–35} In 2008, blacks and Hispanic Americans constituted 1.1% and 2.9% of full professors in medical schools, respectively, while they constituted 3.9% and 5.1% of associate professors.³⁶ Native Americans and Native Hawaiians in 2008 together constituted only 23 of 29,957 full professors (0.08%) and 25 of 26,366 associate professors (0.09%) in medical schools.

An inhospitable academic climate, perceived institutional discrimination in promotions and tenure, inadequate mentoring, and “academic isolation” of minority faculty in academic health centers have been reported by numerous authors.^{37,38} Price et al³⁹ report a recent study showing that URM faculty were significantly more likely to feel that faculty recruitment was biased, were less likely to be satisfied with the level of racial/ethnic diversity in their institution, and were less likely to feel that they would remain in the same institution after five years. It has been shown that major disparities in the attainment of senior-level faculty positions between minorities and nonminorities persist even after controlling for research productivity, seniority, and aspiration.²⁷ Such disparities are evident in that minorities are less likely to be promoted to senior-level faculty appointments and that these promotions take longer to attain compared with those for white faculty. Overall, there are no explanations for the discrepancy in faculty promotions, except for the possibility of discrimination. Some authors suggest that stereotypes of minority groups “permeate the world of academia” and

* This figure represents total minorities including Asian Americans and Pacific Islanders.

that cultural differences may impede minority faculty from collaborations with others, a key to academic success.²⁷

The current measures of meritorious academic performance and the typical arguments for diversity often lead to “pigeonholing” of minority health professions faculty. Because minority faculty are vastly underrepresented in most medical schools, many engage in diversity-related activities, such as institutional committees, speaking engagements, external advisory boards, community service, and other activities related to promoting diversity.⁴⁰ In addition, minority faculty may be positioned to take on excessive mentorship responsibilities, at times mentoring students who have great social and academic needs.¹³ These activities may place undue burdens on minority faculty, making it difficult for them to develop a strong research program and possibly impeding their faculty development and academic promotion.

In addition to these burdens, a report commissioned by the Institute of Medicine (IOM) on processes related to government-sponsored cancer research and minority health issues illuminated significant findings related to minority investigators’ perceptions of their experiences competing for research grants.⁴¹ Minority scientists reported aspects of the peer-review and priority-setting processes to be “problematic” for issues related to minority and medically underserved populations. Minorities are underrepresented among investigators with National Institutes of Health (NIH) research grants. In 2002, blacks and Hispanic Americans constituted 0.8% and 2.3%, respectively, of investigators receiving research program funds from the NIH.⁴² Lack of research funds impedes the ability of minority health professions schools to support research, young investigators, and graduate students.

How HBCUs and Other Minority-Serving Institutions Increase Diversity in Medical Education

Minority-serving institutions are colleges and universities that are committed in their mission to supporting URM students in attaining higher education, that have a high enrollment of minorities (usually above 25%), or that are

designated by a federal act as MSIs.⁴³ MSIs include HBCUs, Hispanic-Serving Institutions, Asian American and Pacific Islander Institutions, and Tribal-Serving Institutions. Today, four predominantly black medical schools are in operation—two that did not close after Flexner’s report and two that have opened since. There are now 17 MSIs with medical colleges, including three schools with a high enrollment of Native Americans, three medical schools in Puerto Rico, and the University of Hawaii John A. Burns School of Medicine, which has a high enrollment of Asian Americans, Native Hawaiians, and Pacific Islanders.⁴³

There are a number of medical schools with creative diversity initiatives, some of which have achieved high minority enrollment. For example, the following schools have minority enrollment rates that meet or exceed minority representation in the general population: the Sophie Davis School of Biomedical Education in New York City; the University of New Mexico School of Medicine in Albuquerque, New Mexico; the University of Texas Medical Branch at Galveston School of Medicine in Galveston, Texas; the University of California, San Francisco School of Medicine in San Francisco, California; and Duke University School of Medicine in Durham, North Carolina.

To date, HBCUs and other MSIs continue to provide the baccalaureate education of a large share of the country’s black physicians and dentists and, in particular, minority senior-level medical faculty who ultimately teach in institutions across the country. Until the 1960s, black medical schools were the primary producers of black physicians in the United States; black medical schools educated approximately 85% of all black medical students.⁴⁴ However, with the emergence of other MSIs and the racial integration of all medical colleges, the annual percentage of black medical graduates produced by Howard, Meharry, Morehouse, and Drew decreased to 14.1% of all black U.S. medical graduates by 2007.⁴⁵

MSIs are among the top institutions producing minority applicants to medical schools, and not surprisingly, these institutions also enroll a high number of minority medical students. In 2007, Howard University School of Medicine,

Meharry Medical College, and Morehouse School of Medicine accounted for more than 18% of black matriculants in medical school.¹³ Similarly, in that year the University of Puerto Rico School of Medicine, the Universidad del Caribe School of Medicine, and Ponce School of Medicine together accounted for 17.4% of Hispanic matriculants.³⁶

It is evident that MSIs produce a significant percentage of minority academic medicine faculty. In 2008, 16.7% of URM senior-level faculty members were situated in one of the predominantly black medical schools or in one of the Puerto Rican schools.³⁶

Because they educate students from humble socioeconomic backgrounds, minority health professional schools have struggled financially. These schools have a history of modest revenue sources, including a low tuition base, smaller endowment, and fewer federal research grants.⁴⁴ Minority health professions schools depend on Title VII funding to support their educational mission. The Title VII programs have undergone severe reductions in recent years, and most of these institutions have been adversely affected as a result.⁴³

Limited funds, smaller faculties, and a heavy teaching commitment challenge the research activity in minority health professions schools. Because research grants constitute a significant proportion of the revenues of schools of medicine, limited research funds at minority health professions schools impact their optimal development.

The Sullivan Alliance: Creating Meaningful Partnerships

The Sullivan Alliance to Transform America’s Health Professions is a culmination of two landmark initiatives for addressing the dearth of minority health professionals in the nation. Two reports appeared in 2004: the IOM report, *In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce*,³⁴ and the Sullivan Commission report, *Missing Persons: Minorities in the Health Professions*.⁴⁶ These reports issued 25 and 37 recommendations, respectively, and provide a comprehensive blueprint for achieving diversity and enhancing

cultural competence in the nation's health workforce.

The Sullivan Alliance was formed in 2005 to stimulate efforts to diversify the nation's health workforce. The Sullivan Alliance serves as a catalyst for the implementation of the recommendations from the IOM committee and the Sullivan Commission. The Sullivan Alliance focuses on increasing racial and ethnic diversity in medicine, nursing, dentistry, psychology, public health, and other health disciplines by promoting the development of statewide and regional consortiums of organizations who share this vision. In September of 2004, the Virginia–Nebraska (VA–NE) Alliance was formed, bringing together all of Virginia's HBCUs, as well as all of the academic health centers in Virginia and the only academic health center in the state of Nebraska (a total of 12 institutions), to increase the successful matriculation of minorities into health professions schools. The program has been successful in strengthening the preparation of undergraduate students to enter health professions schools and in fostering productive partnerships between undergraduate and health professions faculty, enhancing their research programs. The VA–NE Alliance facilitates faculty exchange programs, which allow faculty in different institutions to collaborate in research and educational programs. To date, 24 minority faculty members and 141 minority students have participated in the VA–NE Alliance programs. Twenty-two VA–NE Alliance alumni are currently enrolled in or have been accepted to medical schools, and four are in doctoral programs in pharmacy. Three faculty members at HBCUs within the VA–NE Alliance have received NIH research grants through collaborations with faculty at academic health centers in the VA–NE Alliance, enhancing the development of independent research in these undergraduate institutions. VA–NE Alliance activities include health science programs, pre-health-career development programs, summer research programs, postbaccalaureate programs, BS-to-MD tracks, and MCAT preparation programs. The VA–NE Alliance also includes a faculty development fellowship and a summer fellowship for junior faculty investigators. The Sullivan Alliance affords ongoing communications between the programs

participating in student enrichment. In addition, students at Sullivan Alliance institutions are able to participate in multiple enrichment programs as they progress through their undergraduate education.

In a recent survey, VA–NE Alliance student participants reported that mentorship and networking opportunities, introduction to research, and acquisition of test-taking skills were all seen as major program benefits.

Discussion

A century after the release of the Flexner Report, blacks and other ethnic and racial minorities remain vastly underrepresented among physicians and other health professions. Moreover, much like Flexner's report, arguments for diversity typically fail to emphasize the benefits to *all* of medicine and society, focusing instead on the benefits of diversity for minority trainees and patient populations. Persistent educational inequalities and economic barriers continue to make medical education beyond reach for many minorities. Moreover, too few minorities have achieved senior positions in academic medicine.

The modest gains in ethnic and racial diversity in medicine are disquieting given the panoply of interventions undertaken over time by schools, the federal government, private foundations, the AAMC, and other professional associations. These interventions span a large portion of the educational pipeline. They include enrichment programs in mathematics and sciences, pre-health-career preparation, prematriculation interventions, summer research programs, school partnerships, faculty enrichment, individual and institutional support, and national and regional campaigns spearheaded by health professions schools, professional societies, accreditation bodies, and the federal government.^{43,47}

It is widely accepted that daunting disparities in primary and secondary education and challenges to race-conscious admissions have contributed to the stagnation in URM enrollment into doctoral-level health professions programs in the past three decades.^{16,22} Critical reviews of diversity strategies to

date suggest the need for improvements in approaches to address these significant disparities. Currently there is no national, overarching, coordinated effort to remedy the deficiencies pertaining to health workforce diversity. Grumbach et al⁴⁷ found in their 2003 review of strategies to diversify health professions that discontinuity of interventions across regions and across stages of the educational pipeline make it difficult to sustain gains from one educational stage to the next. They concluded that room for improvement includes better coordination and articulation between programs and funders.

Conclusions

Dramatic social changes and technological advances in the past century have led to the recognition that medical schools and the other health professions schools must address some major challenges if they are to produce the health workforce needed for serving American communities in the 21st century. This presents an opportunity to change the paradigm for educating, evaluating, and incentivizing health professionals.⁴⁸

Achieving diversity in the health professions will occur in a system that strives to strengthen the entire educational pipeline through a series of sustainable and integrated efforts. It will require a system that provides all of its participants an equal and unimpeded opportunity to achieve a long-lasting, rewarding career. To secure sustainable gains in diversifying the health professions, efforts should extend beyond increasing the numbers of minorities graduating from health professions schools to supporting long-term career trajectories.

In 2004, the Sullivan Commission on Diversity in the Healthcare Workforce stated that increasing URM representation among health professionals would require diversification of URM medical school administrators and faculty.⁴⁶ Until then, diversification efforts had focused on increasing minority student recruitment and retention but had neglected career development and job satisfaction. The Sullivan Commission stated the importance of having URM faculty participate in leading the way in

recruitment efforts, and setting the direction of medical education and curriculum reform. To promote equity in academic medicine and avoid the “revolving door” of minority faculty, we must reexamine the culture of medical research. Peer review should be diversified to broaden the perspectives of meritorious contributions and provide proper academic rewards for scholars engaging in clinical research, behavioral studies, diversity efforts, cultural competency initiatives, and community-based interventions.

Working alliances among stakeholders within and between states to diversify the health professions should be encouraged. Such efforts, like the Sullivan Alliance, can be instrumental in building networks and collaborations, fostering partnerships, sharing resources, decreasing academic isolation, and increasing success rates of academic programs. Title VII funding and other sources should support pipeline enrichment programs as well as the infrastructure and educational capacity at MSIs.

Strategic alliances between majority and minority schools can offer viable ways to strengthen the research activities of both institutions while expanding the scope of scientific investigations. Such alliances can provide a unique opportunity for faculty, students, and administrators at majority and minority institutions.

Access to a health professions career should be available to all, not only because of issues of equity and social justice but because without such diversity, we as a nation will not benefit from developing the talent, creativity, and potential of the human capital that exist in all segments of our society.

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Did You Know?

In 1810, faculty at the Baylor College of Medicine and the University of Pennsylvania School of Medicine published the first anatomy textbook.

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