

HOD ACTION: Council on Medical Education Report 6 adopted and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-A-11

Subject: Implementation of Accreditation Standards Related to Medical School Diversity

Presented by: Baretta R. Casey, MD, MPH, Chair

Referred to: Reference Committee C
(Robert J. Havlik, MD, Chair)

1 Policy D-295.322, “Increasing Demographically Diverse Representation in Liaison Committee on
2 Medical Education-accredited Medical Schools,” (AMA Policy Database), asks our American
3 Medical Association (AMA) to undertake the following action:

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5 To study medical school implementation of LCME standard IS-16 and report the results no
6 later than the 2011 Annual Meeting of the AMA House of Delegates.

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8 This report addresses Liaison Committee on Medical Education (LCME) accreditation standards
9 IS-16 and MS-8, which are included as an attachment to this report. Standard IS-16 addresses
10 diversity at the institutional level and standard MS-8 addresses the availability of a diverse national
11 medical school applicant pool.

12 THE DEVELOPMENT OF STANDARDS IS-16 AND MS-8

13 *Prior Accreditation Standards Related to Diversity*

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15 For many years, the LCME had accreditation standards addressing diversity. Prior to 2009, there
16 were specific standards related to medical students and faculty:

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18 Each medical school should have policies and practices ensuring the gender, racial, cultural,
19 and economic diversity of its students.

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21 The recruitment and development of a medical school’s faculty should take into account its
22 mission, the diversity of its student body, and the population that it serves.

23
24 Both standards were “should” statements. According to LCME definitions, a “should” standard
25 indicates that compliance with the standard is expected in the absence of “extraordinary and
26 justifiable circumstances that preclude full compliance.”^{1, p1}

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28 Data collected from medical schools related to compliance with these standards focused almost
29 exclusively on outcome (that is, the racial and ethnic diversity of the student body and faculty).

30 *The Supreme Court Rulings on Diversity*

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32 The Supreme Court rulings in *Grutter v. Bollinger* (2003) and *Gratz, et al. v. Bollinger, et al.*
33 (2003) laid a framework for a reconsideration of how diversity can be considered in the context of
34 recruitment and retention of medical students.² Based on these decisions, medical schools could
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1 articulate that diversity is a compelling interest that contributes to the educational environment.
2 This premise must be demonstrated in the policies and practices of institutions, not just articulated.
3 Medical schools could, for example, demonstrate that they are working to enhance cultural
4 competence among medical students, improve access to care for vulnerable populations, and
5 mitigate racial and ethnic health care disparities.² Based on a legal analysis in 2003, the
6 Association of American Colleges (AAMC) provided the following recommendations to medical
7 schools when considering the issue of diversity in medical student admissions:²

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- 9 • Specify the reasons why having a racially and ethnically diverse student body is
10 educationally valuable;
- 11 • Adopt a definition of diversity that includes, but is not limited to, racial and ethnic
12 diversity; and
- 13 • Ensure that applicants receive individualized, holistic consideration using a flexible
14 policy in which race and ethnicity are one of a number of factors.
- 15

16 *Response of the AAMC and the AMA*

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18 The AAMC has developed guidance documents to support medical schools in developing and
19 implementing policies and practices consistent with the new legal definitions. In addition to the
20 2003 document describing the implications of the US Supreme Court rulings for medical school
21 admission,² the AAMC published informational reports summarizing approaches to research on the
22 impact of diversity in education³ and on integrating holistic review into the medical school
23 admission process.⁴ The AMA and the AAMC held a joint invitational conference on medical
24 school admission in December 2009, which addressed, among other issues, the status of holistic
25 review in broadening the pool of medical school applicants. For more information on the outcomes
26 of the AMA/AAMC conference, consult Council on Medical Education Report 3-A-11.

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28 *Response of the LCME*

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30 In June 2005, the LCME and the Committee on the Accreditation of Canadian Medical Schools
31 (CACMS) held a joint retreat on the subject of diversity. The LCME and the CACMS jointly
32 accredit medical education programs in Canada. One of the recommendations from the retreat was
33 to create a working group on diversity with membership from the two accrediting bodies. The
34 working group, formed in the fall of 2005, was charged to: 1) clarify the aims of and evaluate the
35 effectiveness of existing accreditation standards related to medical student and faculty diversity; 2)
36 identify appropriate outcome measures to assist the committees in determining if the existing
37 standards were achieving their intended aims; and 3) recommend new and/or modified standards
38 related to student and faculty diversity. The working group met during the 2005-2006 and 2006-
39 2007 academic years. As part of its preparation, the working group sought input from individuals
40 representing a variety of perspectives related to diversity.

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42 Also during that time, the two LCME Secretaries, along with staff from other health professions
43 accrediting bodies, met with the Sullivan Alliance to Transform America's Health Care
44 Professions. The goal of the session was to discuss the role of accreditation in enhancing diversity
45 in the health professions.

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47 At the June 2007 LCME meeting, the working group on diversity presented a recommendation to
48 replace the existing diversity standards with two new standards that would eventually become
49 IS-16 and MS-8. The standards each contain explanatory annotations to assist medical schools and
50 survey team members in understanding the meaning and expectations of the standards.

1 LCME Expectations for Institutional Diversity (IS-16)

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3 The working group and the LCME conceptualized diversity as an institutional issue in that it was
4 based in the mission and goals of the institution and articulated expectations for the environment in
5 which education takes place. The new standard on student and faculty diversity (IS-16), therefore,
6 was placed in the Institutional Setting section of the standards. The standard states the following
7 expectations:

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 - 10 • A medical education program and/or its parent institution must have formal policies
11 and supporting practices that will achieve the diversity goals articulated by the
12 institution for its medical students, faculty, staff and other members of the academic
13 community; and
 - 14 • The institution must engage in ongoing and focused efforts to meet and maintain its
15 diversity goals.

16 To determine if medical schools are in compliance with this standard, the LCME asks educational
17 programs to provide the following information as part of the preparation for a regular accreditation
18 review:

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 - 21 • A copy of the current institutional mission statement(s) and policies related to
22 diversity, along with a description of how they were developed and how they are made
23 widely known;
 - 24 • A description of how the institution defines diversity for its students, faculty, and staff;
 - 25 • A description of how, in the context of its definition of diversity, the institution
26 implements polices related to: 1) student recruitment, selection, and retention; 2)
27 financial aid; 3) the educational program; 4) faculty and staff recruitment, employment,
28 and retention;
29 5) faculty development; and 6) liaison activities with community organizations; and
 - 30 • A report on the percentage of enrolled students and employed faculty and staff in each
31 of the diversity categories defined by the institution.

32 LCME Expectations for Supporting a Diverse Applicant Pool (MS-8)

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34 The working group and the LCME also formalized the expectation that medical schools were
35 responsible for developing and supporting diversity in the national pool of well-prepared applicants
36 for medical school, not just for recruiting diverse applicants to their own institution. This
37 expectation is stated in standard MS-8, which was placed in the section of the standards dealing
38 with medical school admissions.

39
40 To determine if medical schools are in compliance with this standard, the LCME asks educational
41 programs to provide the following information as part of the preparation for a regular accreditation
42 review:

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 - 45 • The resources available to the medical school to enhance diversity in the applicant pool
46 (such as an office and/or staff with dedicated time for diversity programs);
 - 47 • The programs available at the medical school to enhance diversity in the applicant pool
48 (for example, outreach programs to secondary schools and colleges), along with the
49 enrollment in such programs, the length of time the programs have been in existence,
50 the funding source(s) for such programs, and the community partnerships that support
such programs; and

- The outcomes of the programs, including the number of participants that enrolled in any medical school.

Approval of the Diversity Standards

Consistent with the process for approval of new standards, the two standards were approved by the AMA Council on Medical Education and the AAMC Executive Council and then presented at a public hearing in the fall of 2007. After consideration of comments at the hearing, the two standards were approved by the LCME at its meeting of February 2008. They became effective in July 2009.

OUTCOMES TO DATE

Medical School Actions

Based on the 2003 Supreme Court rulings, medical schools can take diversity into account as part of a holistic review process for medical school admission. The 2009-2010 LCME Annual Medical School Questionnaire asked whether medical schools used specific criteria in screening applicants to receive a secondary application and to be selected for an interview. Of the 130 medical schools with students enrolled, 33 used potential contribution to diversity (e.g., distance traveled) as one of the criteria for applicants to receive a secondary application and 112 used this concept as one of the criteria for selecting applicants for an interview.

Council on Medical Education Report 3-A-11, "Medical School Admissions," to be considered at this meeting of the AMA House of Delegates, will provide more information on current admissions practices, including the move to use a more holistic admissions process.

LCME Actions

Standards IS-16 and MS-8 were first applied to educational programs with accreditation reviews taking place during the 2009-2010 academic year and following. Of the 24 medical schools whose full survey reports were reviewed by the LCME during the four meetings held between October 2009 and October 2010, six were cited for partial or substantial non-compliance with one or both of the standards (three for IS-16 only, one for MS-8 only, and two for both). The LCME reviews of schools are held confidential. Therefore, it is not possible to report the specific concerns that triggered the citations. The 25% citation rate is not uncommon for new standards that have requirements that schools were not previously expected to meet.

In the 2009-2010 academic year, the LCME began to identify "exemplar practices" for commonly cited accreditation standards. This is a process that will allow the LCME to collect and share examples of how schools achieve compliance with standards. It is not meant to specify a "right way" to meet a standard; rather it aims to provide options for schools. When several exemplar practices are identified for the selected standards, medical schools with these practices will be asked to prepare a summary of their approach that will be available to other medical schools.

RELEVANT AMA POLICY

Our AMA has numerous policies and directives supporting diversity in the medical education learning environment, including faculty diversity (Policies H-350.968 "Medical School Diversity," and H-350.960 "Underrepresented Student Access to US Medical Schools"). The AMA also supports programs to enhance diversity in the medical school applicant pool as a way to contribute

1 to a diverse physician workforce (D-200.982 “Diversity in the Physician Workforce and Access to
2 Care”). The AMA recognizes that such diversity could contribute to reducing racial and ethnic
3 health care disparities (E-9.121, “Racial and Ethnic Health Care Disparities”).

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5 SUMMARY AND RECOMMENDATIONS

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7 The new LCME standards are broader than those formerly in place, in that they state the
8 expectation for a systematic and coordinated process to enhance diversity at the institutional level
9 and at the level of the national applicant pool. The standards are new, however, and most medical
10 schools have not undergone a full review that includes an evaluation of how well they meet these
11 expectations. The Council on Medical Education, therefore, recommends that the following
12 recommendations be adopted and that the remainder of the report be filed:

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14 1. That our American Medical Association (AMA) request that the Liaison Committee on
15 Medical Education regularly share statistics related to compliance with accreditation standards
16 IS-16 and MS-8 with medical schools and with other stakeholder groups. (Directive to Take
17 Action)
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19 2. That our AMA, in collaboration with the Association of American Medical Colleges, continue
20 to monitor medical school implementation of processes to enhance the diversity of medical
21 students, residents, and medical school faculty and report back on the results at the 2013
22 Annual Meeting of the AMA House of Delegates. (Directive to Take Action)
23
24 3. That our AMA rescind Directive D-295.322 [1], “Increasing Demographically Diverse
25 Representation in Liaison Committee on Medical Education Accredited Medical Schools.”
26 (Rescind HOD Policy)

Fiscal Note: Less than \$500.

ATTACHMENT

DIVERSITY STANDARDS (IS-16 and MS-8)

IS-16. An institution that offers a medical education program must have policies and practices to achieve appropriate diversity among its students, faculty, staff, and other members of its academic community, and must engage in ongoing, systematic, and focused efforts to attract and retain students, faculty, staff, and others from demographically diverse backgrounds.

Explanatory Annotation

The LCME and the CACMS believe that aspiring future physicians will be best prepared for medical practice in a diverse society if they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment will facilitate physician training in:

- Basic principles of culturally competent health care.
- Recognition of health care disparities and the development of solutions to such burdens.
- The importance of meeting the health care needs of medically underserved populations.
- The development of core professional attributes (e.g., altruism, social accountability) needed to provide effective care in a multidimensionally diverse society.

The institution should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. The institution should consider in its planning elements of diversity including, but not limited to, gender, racial, cultural, and economic factors. The institution should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty members, staff, and others.

MS-8. A medical education program must develop programs or partnerships aimed at broadening diversity among qualified applicants for medical school admission.

Explanatory Annotation

Because graduates of U.S. and Canadian medical schools may practice anywhere in their respective countries, it is expected that an institution that offers a medical education program will recognize its collective responsibility for contributing to the diversity of the profession as a whole. To that end, a medical education program should work within its own institutions and/or collaborate with other institutions to make admission to medical education programs more accessible to potential applicants of diverse backgrounds. Institutions can accomplish that aim through a variety of approaches, including, but not limited to, the development and institutionalization of pipeline programs, collaborations with institutions and organizations that serve students from disadvantaged backgrounds, community service activities that heighten awareness of and interest in the profession, and academic enrichment programs for applicants who may not have taken traditional pre-medical coursework.

REFERENCES

1. Liaison Committee on Medical Education. *Functions and Structure of a Medical School*, June 2010 edition.
2. Association of American Medical Colleges. *Assessing Medical School Admissions Policies: Implications of the US Supreme Court's Affirmative-Action Decisions*. Washington, DC: AAMC, 2003.
3. Association of American Medical Colleges. The Diversity Research Forum. "Tools for Assessing and Measuring Diversity in Medical Education." Washington, DC: AAMC, 2006.
4. Addams A, Bletzinger RB, Sondheimer HM, While SE, Johnson LM. *Roadmap to Diversity: Integrating Holistic Review into Medical School Admission Processes*. Washington, DC: AAMC, 2010.