HOD ACTION: Council on Medical Education Report 3 adopted and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-13

Subject: Implementation of Accreditation Standards Related to Medical School Diversity

Presented by: Mahendr S. Kochar, MD, Chair

Referred to: Reference Committee C
(A. Patrice Burgess, MD, Chair)

Policy D-295.963, Continued Support for Diversity in Medical Education paragraphs #2 and #3, calls on our American Medical Association (AMA) to:

> Request that the Liaison Committee on Medical Education (LCME) regularly share statistics related to compliance with accreditation standards IS-16 (Institutional Diversity) and MS-8 (Pipeline Programs) with medical schools and other stakeholders; and
>
> In collaboration with the Association of American Medical Colleges (AAMC), continue to monitor medical school implementation of processes to enhance the diversity of medical students, residents, and medical school faculty and report back on the results at the 2013 Annual Meeting of the AMA House of Delegates.

This report: 1) summarizes the status of implementation of the LCME diversity standards and describes the steps taken by the LCME to assist schools in achieving compliance; 2) provides data on trends in medical student, resident, and faculty diversity; and 3) describes current strategies to enhance medical school diversity.

Accreditation standards IS-16 and MS-8 are included as an attachment to this report.

STATUS OF COMPLIANCE WITH DIVERSITY STANDARDS

LCME diversity standards IS-16 and MS-8 went into effect in July 2009 for medical schools with accreditation reviews in the 2009-2010 academic year. Since that time, medical schools must provide evidence of how they are addressing the expectations of the two standards.

Requirements of the Standards

In summary, accreditation standard IS-16, institutional diversity, requires that there be policies and practices aimed at achieving institutional diversity. Institutions must explicitly define the categories of diversity that will add value to the learning environment; implement focused efforts to attract and retain medical students, faculty, and staff from the value-added categories; and evaluate the results of their efforts. Accreditation standard MS-8, pipeline programs, states the expectation that medical schools, alone or in partnership, develop outreach activities aimed at broadening the pool of diverse medical school applicants.

Current Level of Compliance with the Diversity Standards

Of the 25 schools with full reviews by the LCME between October 2011 and June 2012, IS-16 (institutional diversity) was the most commonly-cited standard. There were 13 schools reviewed by the LCME during that period that received a citation for IS-16. Of these, 10 schools were identified as not being in compliance with the standard and three were in compliance but required follow-up to assure that compliance would be maintained and/or efforts made to date would be successful.

The LCME reviewed the reasons for the citations, which were one or more of the following: 1) the absence of specified diversity categories that the school believes add value to the learning environment; 2) the lack of processes and practices focused on the recruitment and/or retention of individuals (students and/or faculty) from the identified diversity categories; 3) the absence of a process to collect data on diversity outcomes; and 4) the inability of the school to meet its own diversity goals.

Standard MS-8 (pipeline programs) was not cited as a separate area of noncompliance between October 2011 and June 2012, in that all medical schools could document the presence of one or more programs. Collectively, there are a variety of types of pipeline programs. For example, programs differ in the age group that is targeted. For example, some programs reach back to primary or middle school, while others are directed at high school or college students. Programs also differ in the content that is included. Programs for younger students may attempt to create an interest in the sciences or in health careers, while programs for college students and postbaccalaureate programs aim to provide the skills necessary to be a competitive applicant.

LCME Actions to Support Compliance

The LCME has engaged in a variety of actions to inform schools of the expectations of the diversity standards and to share the data (cited above) on the reasons for noncompliance. These include presentations at national meetings, development of written documentation to describe the expectations of the standards, consultations with individual schools, and open question and answer sessions involving administrators and faculty from groups of schools. The LCME plans to continue to collect data on the extent of and reasons for noncompliance and will make this information widely available.

MEDICAL STUDENT, RESIDENT, AND FACULTY DIVERSITY

Data for this section are derived from publications of the Association of American Medical Colleges (AAMC) and the AMA.

Medical Students

Data will provide comparisons between the 2003 and 2011 entering classes. In 2002, the AAMC changed the way data on race and ethnicity were collected, allowing multiple responses from a given individual (for example, an individual could select a Hispanic ethnicity alone or in combination with any race). This new way of categorizing data does not allow comparisons with earlier years.

The percentage of women among medical school applicants and matriculants reached an all-time high for the entering class in 2003 (50.8% of applicants and 49.6% of matriculants) and has decreased slightly since that time. For the 2011 entering class, 47.3% of applicants and 47.0% of matriculants were women.[1] These percentages must be considered in the context of the national increase in medical school enrollment. The number of medical students in the 2003 entering class was 17,118 and in the 2011 entering class was 19,719.[2] The absolute number of women applying to medical school (34,792 in 2003 and 43,919 in 2011) and the number of matriculants (8,212 in 2003 and 9,037 in 2011) have increased.[1]

1 The following table compares the number and percentage of applicants and of first-year students by
2 race and Hispanic ethnicity for the 2003 and 2011 entering classes. Note that the data for the entering
3 class includes students repeating the year.

US Medical School Applicants and First-year Students by Race and Ethnicity, 2003 and 2011[1]				
Race, Alone or in Combination, Non-Hispanic Number (% of Total)				
	2003		2011	
	Applicants	First-Year	Applicants	First-Year
Black/African-American	2,963 (8.5%)	1,277 (7.5%)	3,407 (7.8%)	1,384 (6.9%)
American Indian/Alaskan Native	342 (1%)	160 (0.9%)	308 (0.7%)	129 (0.6%)
Asian/Pacific Islander	6,834 (19.6%)	3,515 (20.6%)	9,818 (22.4%)	4,442 (22.3%)
Native Hawaiian/Other Pacific Islanders (OPI)	98 (0.3%)	37 (0.2%)	139 (0.3%)	52 (0.2%)
Hispanic, of any Race Number (% of Total)				
US Hispanic	2,491 (7.2%)	1,157 (6.8%)	3.459 (7.9%)	1.707 (8.6%)

4 *Residents*
5
6 As with medical students, the number of residents increased between 2003 and 2011. There were
7 99,694 residents on duty in Accreditation Council for Graduate Medical Education-accredited
8 programs in 2003 and 113,427 residents on duty in 2011. In 2003, 41% of residents in ACGME-
9 accredited programs were women.[3] In 2011, the percent of women was 46.3%.[4]
10
11 The following table compares the number of and percentage of resident physicians by race and
12 Hispanic ethnicity for the 2003 and 2011 years.

US Resident Physicians in ACGME-Accredited Programs by Race and Ethnicity, 2003 and 2011[3,4]		
	2003	2011
	Race, Alone or in Combination, Non-Hispanic Number (% of Total)	
Black/African-American	5,359 (5.4%)	6,901 (6.1%)
American Indian/Alaskan Native	225 (0.2%)	413 (0.4%)
Asian/Pacific Islander	25,623 (26.5%)	31,975 (28.2%)
	Hispanic of any Race Number (% of Total)	
Hispanic	6,578 (6.6%)	9.013 (7.9%)

Medical School Faculty

In 2011, there were 136,373 full-time faculty members in US medical schools. Of these, 49,017 (35.9%) were women. Women were more highly represented in lower academic ranks. In the basic science departments, 22.0% of the faculty at the professor level were women and in the clinical departments, 18.9% were women. In contrast, 40.0% of faculty at the assistant professor level in the basic science departments and 42.4% of the faculty in the clinical departments were women.[5]

Also in 2011, 12.5% of medical school faculty of all ranks were Asian, 2.9% were Black/African American, 0.1% were Native American/Alaskan Native, and 0.1% were Native Hawaiian/OPI and 4% were Hispanic. Faculty data on race and ethnicity have gaps, in that 17.1% of faculty are of unknown race. The racial and ethnic composition of the faculty has been relatively constant over the past five years.[1]

ACTIONS TO ENHANCE DIVERSITY AT THE BEGINNING OF THE PIPELINE

This section will focus on processes that are being used to build a diverse pipeline into the medical profession, starting with medical school admissions.

Creating a Pipeline to Medical School

As specified in LCME accreditation standard MS-8, medical schools are expected to participate in outreach programs to enhance the pool of medical school applicants and to monitor the success of their efforts. The LCME requires that medical schools monitor the outcomes of pipeline programs, including the success of students in gaining entry to medical school. Success is defined as contributing to the national pool of medical students from diverse backgrounds, not just increasing the applicants to the specific medical school responsible for the program.

Programs may be supported through *institutional* funds or through national funding programs. For example, the Summer Medical and Dental Education Program (SMDEP), funded by the Robert Wood Johnson Foundation and managed through the AAMC and the American Dental Education Association, provides college students with academic enrichment in the basic sciences and mathematics, clinical experiences, learning and study skills, and career development activities. Outcome data indicate that the program has a good record of preparing its graduates for entry into the health field.[6]

Categories of Diversity and Race Neutral Admissions

As a result of various court opinions and state legislation, the ability to use criteria such as race, gender, color, or ethnicity as explicit factors in admission has been limited in certain regions. Replacement variables have included socioeconomic factors (e.g., socioeconomic disadvantage, educational disadvantage), adversity indices (e.g., distance traveled), or institutional mission-based practices.[7]

Holistic Review Admissions Process

Holistic review has been defined as a flexible, individualized process in which consideration is given to multiple ways that applicants can demonstrate suitability as medical students and future physicians. In this context, applicants for admission are evaluated through institution-specific criteria that are mission-driven.[8] Diversity, as defined by the institution, is one element that can be taken into account in the admissions process. Diversity, as noted above, may be defined in a variety of ways.

AMA POLICY

The policy of our AMA strongly supports the concept that a racially and ethnically diverse educational experience results in a better educational process H-200.952. In that context, the AMA will continue to advocate for programs that promote diversity in the medical workforce, such as pipeline programs, financial aid programs for students from groups underrepresented in medicine, and diversity affairs offices in medical schools D-200.982; D-200.985. In addition, our AMA recognizes the importance of a diverse faculty in the recruitment and retention of a diverse student body H-350.968. Policy suggests financial support programs to recruit and retain a diverse faculty D-200.985.

CONCLUSIONS AND RECOMMENDATIONS

The standards of the LCME focus on creating a diverse medical school environment. The desired outcomes of this attention to diversity are twofold: 1) to enhance the educational experience for all students; and 2) to support the development of a workforce that will lead to a mitigation of health disparities.[9] Standards IS-16 and MS-8 are relatively recent and outcomes are, to date, unavailable. Therefore, the Council on Medical Education recommends that the following statements be adopted and the remainder of this report be filed:

1. That American Medical Association Policy D-295.963 (# 2) be reaffirmed. (Reaffirm HOD Policy)

2. That AMA Policy D-295.963 (#3) be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than $500

ATTACHMENT

ACCREDITATION STANDARDS IS-16 AND MS-8
(From: *Functions and Structure of a Medical School*, May 2012 edition)

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 premedical coursework.

References

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5. AAMC Databook, Table C5. US medical school faculty counts by gender, rank, and department, 2001. AAMC, Washington, DC, 2012.

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8. Addams A, Bletzinger RB, Sondheimer HM et al., Roadmap to Diversity: Integrating Holistic Review Practices into Medical School Admissions Processes. AAMC, Washington, DC, 2010/

9. Coleman A, Palmer S, Winnick S et al., Roadmap to Diversity: Key Legal and Educational Policy Foundations to Medical Schools. AAMC, Washington, DC, 2008.