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FROM THE EDITOR

Motivating Health Justice and Diversity Through Medical School Admissions

Jewel Mullen, MD, MPH, MPA and David Henderson, MD

It is undeniable that bigotry and discrimination predate the official founding of our nation, even if we only consider the status and treatment of Indigenous populations, enslaved Africans, and women. The civil rights movement of the mid-20th century contributed to the passage of civil rights laws, suggesting the promise of national progress on human rights overall. However, during the summer of 2020, as a nation we found ourselves facing a raging pandemic and protests sparked by police violence against George Floyd, Breonna Taylor, and Ahmaud Arbery. These 2 crises broke through a rosy façade of cultural progress that had been in place for over half a century and forced us to face the persistence of inequities embedded in our society's foundations. Just as police violence is not simply police misconduct, so inequity floridly manifest in lower rates of COVID testing and vaccination and in higher rates of morbidity and mortality among members of Black, Brown, and Indigenous communities are not just aberrations.^{1,2} Both have roots in long-standing discrimination, racism, and segregation that contribute to inequitable access to quality education, housing, and health care and unequal opportunities for economic advancement and for wealth attainment and accrual.

Questions about justice and diversity in medical school admissions often broaden and deepen an active fault line of conflict that has shaken the foundation of our nation. At a time of full-throated demands for social justice at all levels, how should we frame diversity and justice in medical school admissions? How should we respond to recurring challenges to affirmative action and other equity-minded admissions strategies from groups who contend it was never fair or is no longer needed?

Despite ongoing **debate over affirmative action**, it has directly contributed to diversity in medical education in ways we simultaneously seem to accept and overlook. That White women have been affirmative action's major beneficiaries is rarely mentioned. Between 1980 and 2000, the number of women physicians increased by 300%.³ By contrast, between 1978 and 2014, the number of African American male medical school matriculants decreased from 542 to 515 (ie, from 3.4% to 3.0% of matriculants).⁴ Yet, ironically, White women have often litigated affirmative action, as did Abigail Fisher in suing the University of Texas (UT) at Austin in 2016⁵ and Jennifer Gratz in suing the University of Michigan in 2003.⁶ Fisher's case is notable because UT Austin, as part of its admissions process, included consideration of multiple social factors, of which race

was one. Thus, holistic review has been legally challenged as well as affirmative action. Which, if any, features of these examples should be applied to medical school admissions now? Neither affirmative action nor holistic review directly addresses the fundamental injustices it was intended to remediate. If social justice questions dominate our national conversation about medical school admissions, it seems reasonable to ask: How should a **social justice lens** be used to explore and pursue diversity? A social accountability framework offers one such lens.

In 1995, the World Health Organization (WHO) defined medical schools' social accountability as "*the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve*." The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public⁷ and defined in light of 4 ethical and cultural values: relevance, quality, cost effectiveness, and equity. The WHO added: "Accountability exists independently of whether a school acknowledges it and addresses it; all medical schools are accountable."⁷ These statements from the WHO assert the importance of a social accountability as a fourth cornerstone complementing the three traditionally recognized as foundational to medical education: education, research, and clinical care. Concurring with the WHO's conception of social accountability in medicine, the American Medical Association (AMA) in June 2020 defined racism as a public health threat and made an organizational commitment to act against racism, injustice, and police violence.⁸

In September 2019, the AMA also convened a group of medical educators from across the country—the Accelerating Change in Education (ACE) Consortium—which, guided by social accountability as an ethical value, engaged in a "wicked problem"⁹ fishbone exercise to identify drivers of medicine's lack of diversity. The fishbone exercise revealed 6 root causes of inequity in medical education: (1) debt, (2) overreliance on traditional metrics, (3) structural racism, (4) lack of inclusion in health care education and work environments, (5) lack of attention to harmful biases among organizational leaders and institutional processes, and (6) neglect of diversity, equity, and inclusion as key ethical values along professional development pathways. The ACE Consortium cited medical schools' responsibility for implementing changes to address injustices structurally entrenched in classroom and clinic-based teaching and learning cultures, especially those perpetuating inequity through bias in standardized examinations and metrics that prop up myths of meritocracy. Medical College Admission Test® (MCAT) and United States Medical Licensing Examination® (USMLE) scores, for example, do not predict clinical performance quality but do correlate well with family income.^{10,11}

By demanding that "primary attention should be given to those who suffer the most, to ailments that are most prevalent, and to conditions that can be addressed with locally available means,"⁷ the WHO framework suggests how to incorporate social justice in admissions processes. The WHO states: "Medical schools can and should also have some role in defining the composition and distribution of the health workforce most appropriate to meeting the needs of society."⁷ With regard to quality, the WHO maintains that "high-quality health care uses evidence-based data and appropriate technology to deliver comprehensive health care to individuals and populations, taking into account their social, cultural and consumer expectations."⁷ The WHO defines cost-effective health care systems as those with "the greatest impact on the health of a society while making the best use of its resources."⁷

Currently, medical schools have few incentives to meet society's needs, and many aspire to be highly ranked **based on metrics** (eg, grade-point averages, MCAT scores) that indicate neither students' quality nor their merit. In a study of 136 allopathic and 34 osteopathic medical schools' mission statements published in 2014, only 16% named diversity as a prominent theme.¹² Thus, another question is how to respond to such a lack of commitment to **diversity in health care** when evidence has accrued that racial, ethnic, and cultural patient-clinician concordance promotes stronger, more functional relationships and improves patients' adherence and outcomes.^{13,14,15} If we apply the WHO's 4 ethical and cultural values of relevance, quality, cost effectiveness, and equity to medical school admissions processes and practices, we ought not to be satisfied with processes ill-equipped to generate the physician workforce diversity that society needs. Health equity is a product of medical schools' social accountability.

During the civil rights movement of the 1960s, calls for social justice, informed by principles of distributive and procedural justice, manifested not only in ideals and mission statements but also in action. In 2020, restorative and reparative justice again became prominent in national conversations, as it was acknowledged that not all among us have had opportunities to fully realize our common American strivings and inalienable rights to "Life, Liberty and the pursuit of Happiness."¹⁶ We recognize that Thomas Jefferson's words, valiant in mission, failed to be meaningfully enacted in our shared history. As educators, clinicians, and researchers in medicine in our present time, we must improve retention and promotion of diverse students and faculty, foster inclusion, and modify curricular content^{17,18} to build public health capacity; we are accountable for making our fields as diverse as needed so that all are cared for equitably.

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Jewel Mullen, MD, MPH, MPA is the associate dean for health equity and an associate professor of population health and internal medicine at the University of Texas at Austin Dell Medical School.

David Henderson, MD is the chair of the Department of Family Medicine and the associate dean of the Office of Multicultural and Community Affairs at UConn Health in Farmington, Connecticut.

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