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# What Is the Role of Accreditation in Achieving Medical School Diversity?

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## Abstract

Diversity standards in medical education accreditation do not guarantee diversity but do stimulate schools' activities to recruit and retain diverse students and faculty. The Liaison Committee on Medical Education's (LCME's) accreditation standard addressing medical school diversity neither mandates which categories of diversity medical schools must use nor defines quantitative outcomes they should achieve. Rather, each medical school is required to (1) identify diversity categories that motivate its mission and reflect its environment and (2) use those categories to implement programs to promote diverse representation of students and faculty. When the LCME assesses each medical school's compliance with these requirements, it considers single point-in-time diversity numbers, trends in student and faculty diversity, and outcomes of programs implemented by the school to promote diversity in the categories it identifies as key to its mission.

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## Accreditation Stimulates Diversity

The demographic composition of the physician workforce in the United States results from individual and organizational decisions at multiple levels, including by the individual who decides to pursue medicine as a career and apply to specific medical schools and by the medical school that makes the admission and graduation decisions. In the United States, each transitional step leading from primary and secondary school to eventual entry into undergraduate medical education, graduate medical education, and practice is dependent on the pipeline from the previous level. For this discussion, we focus on US MD (doctor of medicine)-granting medical schools, which numerically represent the largest contributor to US residency programs[1] and, consequently, to the physician workforce.

In *Grutter v Bollinger*,[2] the US Supreme Court ruled that the use of race, among other criteria, in admissions was permissible based on the educational benefits of a diverse student body. There is substantial literature supporting that a diverse physician

workforce provides culturally competent health care to a diverse population and is, therefore, both likely and necessary to address existing health inequities.[3,4,5,6] Accreditation has been shown to be one among several mechanisms leading to increased medical student diversity.[7] Proceeding from the premise that a diverse student body confers educational benefits, we discuss the role and limitations of accreditation in shaping medical school diversity activities and outcomes.

## Framing a Diversity Standard

In the United States, medical education programs leading to the MD degree are accredited by the Liaison Committee on Medical Education (LCME). There has been an LCME accreditation standard related to student diversity in the document, "Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree," since 1997,[8] but the relation of this requirement to diversity outcomes has been judged to be unclear.[9,10] There are multiple reasons for this perception, including the degree of congruence between diversity requirements specified in accreditation standards and what stakeholders believe those requirements and resulting outcomes should be and whether schools can and do achieve the outcomes. Although there are barriers to achieving diversity, we describe how accreditation can be utilized to enhance diversity and discuss the implications and limitations of the LCME's specific approach.

National and regional barriers to mandating specific diversity categories, such as race and ethnicity, follow from the national prohibition against requiring quantitative diversity outcomes in accreditation standards. For example, in *Regents of the University of California v Bakke*,[11] the US Supreme Court ruled against using race-based quotas but allowed race to be one factor among others in admission decisions. In addition, California Proposition 209, approved in 1996, prohibited universities from granting "preferential treatment" to applicants based on race, sex, color, ethnicity, or national group.[12] Accreditation standards that apply at a national level, therefore, need to take into account the real and perceived constraints imposed by regulatory and judicial actions.

Accordingly, LCME accreditation Element 3.3, "Diversity/Pipeline Programs and Partnerships," states the following expectation:

> A medical school has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes.[13]

There are consequences to including diversity as a component of accreditation requirements without mandating predefined diversity categories. If diversity is an expectation but specific categories and outcomes are not set by the accreditor, the decision is left to each medical school to identify diversity categories for which it will commit resources and implement recruitment and retention activities. LCME accreditation Element 3.3[13] thus allows flexibility for schools to identify their diversity categories in the context of their missions and environments, including the diversity needs of their regions. For example, the mission of one LCME-accredited medical school is to "transform the Rio Grande Valley, the Americas, and the world through an innovative and accessible educational environment that promotes student success, research, creative works, health and well-being, community engagement, and

sustainable development."[14] Following from this mission statement, the school's diversity policy states in part: "The [medical school's diversity] goals stem from the School's unique geographic location at the border of US and Mexico, a place with rich bicultural and family traditions, but also one burdened by health disparities."[15] Flexibility allows medical schools to contribute to the sum total of national needs in their own way and to use their finite resources to implement programs directed at their selected diversity categories.

In summary, LCME accreditation requirements for diversity allow flexibility, enabling medical schools' diversity policies to reflect local differences, including those imposed by their legal and regulatory environments. This flexibility does not mitigate the requirement that schools seek diversity but rather allows variation in how individual schools define and act to achieve diversity. LCME accreditation requirements, as specified in Element 3.3, are framed to address decision points that directly or indirectly promote diversity by requiring medical schools to do the following[13]:

1. Develop pipeline programs that support the preparation and counseling of individuals from targeted diversity groups for entry into medicine.
2. Create policies and implement practices that focus on recruitment, admission, retention, and support for students from targeted diversity groups.
3. Recruit, hire, and support faculty and administrators from the targeted diversity groups to support the ability to attract and retain a diverse student body.

Element 3.3 can influence recruitment and retention of a diverse student body through medical schools' actions long before students matriculate.

### How the LCME Evaluates Diversity Efforts

The LCME utilizes both process and outcome measures in evaluating medical school performance with respect to Element 3.3. The LCME expects schools to collect data on the numbers of applicants and entrants in their identified diversity categories. How, potentially, can this information be used to judge success? The Association of American Medical Colleges publishes national data on percentages of applicants, enrolled students, and graduates by race and ethnicity,[16] so a given school's success could be judged based on its meeting or exceeding an average percentage of enrolled students for each of its diversity categories, if such data exist. However, differences among schools in missions and in locations, including state laws and requirements, make relying solely on national comparison data problematic, and such data are lacking for some of the diversity categories that schools might include, such as socioeconomically or educationally disadvantaged. In addition, national averages are low and therefore do not provide an appropriate threshold. For example, while the number of enrolled male and female medical students in many diversity categories (eg, Black/African American and Latinx) increased between 2016-2017 and 2020-2021,[16] there remain concerns about the adequacy of the current level of diversity in medical schools.[17]

Instead of relying on normative data, the LCME examines quantitative diversity data for each medical school both at a single point in time and as a trend. In trend evaluation, there is consideration of whether the number and percentage of entering students and employed faculty in each diversity category are increasing, remaining the same, or decreasing over a set number of years. Decisions regarding achievement of success include consideration of the trend line and whether the school has processes in place to identify and address the root causes of poor performance. Such processes include

evaluating activities and resources available for pipeline programs, outreach in recruitment, mentorship, and other support for enrolled students.

### Performance Determination

In judging performance on its diversity standard, the LCME considers if there are appropriate policies and processes in place to support diversity and if outcomes are adequate or trends sufficiently promising to support a positive accreditation decision. The LCME has identified specific criteria for judging performance.[18] The lack of policy, activity/resource allocation, or monitoring/achievement of outcomes results in a finding of "unsatisfactory" performance. Schools strive to achieve diversity by making offers of acceptance to applicants and offers of employment to potential faculty from their identified diversity categories. If these offers do not result in enrollments/hires, they are not included in a school's diversity outcomes data. The LCME recognizes, however, that these offers are indications of the school's commitment and effort to enhance its diversity. The LCME therefore asks for numbers of individuals from a school's diversity categories who were offered admission or who were offered employment for all available faculty and administrative positions and whether these offers were accepted. Effort that results in progress may raise a school from an "unsatisfactory" finding to one in which performance on Element 3.3 is deemed "satisfactory with a need for monitoring."[18] The diversity standard is complex, with a number of expectations. All of these must have been met for the performance on the element to be "satisfactory." In the period encompassing the 2015-2016 to 2020-2021 academic years, of the 112 medical schools reviewed, the performance of 26 was judged to be satisfactory for Element 3.3, 40 to be satisfactory with a need for monitoring, and 46 to be unsatisfactory (LCME, unpublished data, 2021).

Another expectation is that schools will create programs and partnerships to enhance the pool of qualified applicants from the school-identified diversity categories. Such activities, often referred to as pipeline programs, are an LCME requirement, as specified in Element 3.3. Pipeline programs are defined as follows by the LCME:

> A pipeline program is directed at students from selected level(s) of the educational continuum (middle school-level through college) and aims to support their becoming qualified applicants to a medical school and/or, depending on the level of the program, to another health professions program or a STEM/biomedical graduate program.[13]

Medical schools are expected to monitor whether their pipeline programs contribute to diversity in their own student body and in the national applicant pool. Data from the 2019-2020 academic year showed that 138 of 153 LCME-accredited medical schools had pipeline programs.[19] The LCME considers a school's Element 3.3 performance to be satisfactory when graduates of its pipeline program(s) enroll in any medical school. Among 2018 and 2019 matriculants, 872 pipeline program participants entered their program's medical school and 580 entered another MD- or DO (doctor of osteopathic medicine)-granting medical school (LCME, unpublished data, 2020).

### Roles of Accreditors

Among the many groups that could contribute to a diverse physician workforce, accreditors should and do have a role. Analysis of LCME data revealed that Element 3.3 stimulates schools to identify, recruit, and retain a diverse student body.[7] But an accreditation requirement does not itself guarantee success in motivating or achieving diversity. The temptation to make accreditation standards more prescriptive (eg, by mandating specific diversity categories and defining quantitative diversity outcomes)

should be resisted since, even if legally permissible, such standards would not guarantee schools' satisfactory performance in Element 3.3. The LCME acknowledges that a single definition of diversity does not accommodate medical schools well, given the variation in their histories, locations, and the populations they hope their graduates will serve. The LCME also acknowledges that individual schools can promote and contribute to physician workforce diversity in ways unique to their missions.

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