Student National Medical Association
Statement on Diversity and Equity

Health Policy and Legislative Affairs Committee
Statement on Diversity and Equity

Second Revision

Revised and prepared for the 51st SNMA House of Delegates
April 1-5, 2015
New Orleans, LA

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Background

According to 2010 U.S. Census data, the total population of the United States grew by 9.7% between 2000 and 2010. In absolute terms, the population increased by 23.7 million people from 281.4 million in 2000 to 308.7 million in 2010. Of this growth, the Hispanic population accounted for over half of the increase (15.2 million) while the African-American and American Indian/Alaska Native populations combined grew at a faster rate than the total population (18 percent and 12 percent, respectively). By mid-century, over half of the population will be a member of a minority group. This colossal shift in demographics will impact many aspects of the health care system including the doctor-patient relationship and access to health care. Moreover, the Patient Protection and Affordable Care Act (ACA) aims to provide universal insurance coverage to the population at large, thereby granting the means with which to utilize care when needed. The numbers of minorities in the medical profession must mirror this shift in demographics in order to provide optimal care to our citizens. This policy statement will reiterate the importance, if not absolute necessity, of diversity in medicine, argue for an evolution in approach that will incorporate strategies from the past, and outline chronic and contemporary challenges that must be overcome if we are to achieve true equity in the medical landscape.

Scope of the Problem

A diverse health care workforce is necessary to improve patient care in the 21st century because it promotes cultural competency, improves health care access, bolsters the medical research agenda and ensures the establishment of health care management protocols that are optimal given the climate.  

1. Patients come with practices, attitudes and beliefs that affect their health both positively and negatively. Increasing ethnic and cultural diversity in health professional schools will create an environment of learning through exposure, forcing students to understand the influences of race, gender, sexual orientation and socioeconomic status.

2. Underrepresented minorities in the health care field are more likely to return to neighborhoods and environments from which they came. In this way, the
underserved will be able to access high quality health care from familiar professionals.

3. It logically follows that the medical research conducted by the increased numbers of minority professionals will pertain to conditions affecting minorities. Therefore, the field of research will be more rigorous with results that, when applied, will likely improve health outcomes.

4. Executive and public policy makers that have been medically trained will enter the workforce with unique experiences, contributing to a management team that will be sensitive and responsive to the increasingly diverse system.

Up until this point, Affirmative Action, the collective efforts of the Association of American Medical Colleges (AAMC) and medical schools across the country have made headway towards the goal of diversifying the medical field. In 1964, less than two percent of medical school matriculants were minorities. By 1971, with affirmative action firmly in place, this number had swelled to more than 8 percent. While these increases were impressive, rapid growth in the minority population through the following decades outpaced any gains in matriculation, leading to stagnation in growth. This prompted the much-needed AAMC initiative Project 3000 by 2000.

In 1990, the AAMC initiative Project 3000 by 2000 aimed to increase the representation of minority students in American medical schools to 3000 students by the year 2000. Medical schools were to mobilize in order to find talented minority students who were interested in becoming physicians. Along with that, academic interventions would be in place by high school to ensure that minority students gained the skills necessary for success in the field. With these new efforts in place, between 1990 and 1993, there was a 27 percent increase in new entrants from underrepresented (URM) groups -- from 1470 to 1863. However, these modest gains were short-lived. The tide of anti-affirmative action measures, amongst other variables, hindered the actualization of their goal. Ten years later, the goal was finally reached, with over 3000 current minority students matriculating, but the strides are not enough. Affirmative Action has been met with renewed opposition and is currently in peril following the Fisher v. The University of Texas at Austin case. Programs such as these help to ensure that diversity remains an
important factor considered by schools. The SNMA supports affirmative action as a means to ensure that we adequately diversify the field.

Academic segregation by race and poverty has been consistently linked to poor educational outcomes and opportunities. As it stands, at least 66% of underrepresented minority students in predominately minority pre-college educational systems are sixteen times more likely to attend a concentrated poverty school than students attending segregated white schools. These trends are incredibly concerning and have prompted the members of the SNMA to use our collective voice to influence these troubling tides in education.

Although it took time for the goal of 3000 to be reached, there was an important lesson learned from the project. In order to affect change, it will take a concerted effort in which all of the medical institutions participate. Deans and administrators at institutions must be educated on the importance of making diversity in medicine a priority. Moreover, an initiative for diversity should not just be implemented for students, but faculty and staff as well. A study conducted by Lee and colleagues examined diversity initiatives in the US from the 1960s to the 2000s. Their report discovered an overarching problem: initiatives from the past were not comprehensive and consistent over space and time. 7 Pipeline initiatives in high school and pre-high school to bolster interest and exposure are necessary. Along with these, however, each school must use a mission-driven, multidimensional approach including mission, outreach, admissions, retention, financial aid, cultural competency and professional standards that require the prioritization of diversity in order to effectively diversify. Only when there is a change in culture--when we all realize the beneficial impact that these strides will have on health outcomes--will diversity be achieved.

**Statement of Position and Recommendations**

We, the members of the SNMA are dedicated to fortification of the social and political foundation upon which equitable educational and professional opportunities for underrepresented minorities can be established. Furthermore, we accept the challenge of not only attaining individual and collective successes in medicine, but also of ensuring enhanced opportunities for the next generation. Closing these disparities is imperative
given the responsibility that we as health care professionals have accepted: to provide the best care to each and every patient. The SNMA therefore supports:

1. The redoubling of efforts to promote not only the inclusion, but also the active, calculated and persuasive exposure of URMs to science and medicine at an early age.

2. Equity and excellence in the education and professional preparation of underrepresented minority students from grades K-12.

3. The establishment of equitable access to the highest quality of educational opportunities for students of all ages, circumstances and origins.

4. The efforts of the AAMC and individual medical school institutions that promote diversity and equity in medical education.

5. The development, funding, and strengthening of programs that enroll, retain, and graduate increased numbers of minority students.
References