JAMA Network Open

Invited Commentary | Equity, Diversity, and Inclusion

Understanding and Addressing How Racism Can Affect Medical School Admissions—Making the Invisible Visible

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Available research demonstrates that increased racial and ethnic diversity has positive effects on health care, including patient care, communication, innovation, and financial performance.[1] There has been an increase in the rhetoric of and initiatives aimed at increasing diversity within the medical profession. Despite this, inequities in representation remain at every step of the way—from medical students to senior faculty. This persistent inequity is reflective of institutional racism that can hide in plain sight, even in seemingly impartial processes such as medical school admissions. Currently, there is limited understanding of the ways in which organizational processes within medical schools may help or hinder the achievement of racial justice, and how individuals in positions of power and influence can facilitate or reduce access at pivotal points along the pathway to becoming a physician.

We believe that the study by Ko et al[2] is a call to action for medical school leaders, gatekeepers, and educators who have a unique opportunity to address many of the persistent challenges in advancing diversity within medical schools. Although this qualitative study of a diverse sample of deans and directors of admissions across 37 allopathic schools in the United States was not nationally representative, it nonetheless makes a major contribution to the literature by unmasking processes where racism can operate in medical school admissions. Their analyses revealed several barriers to advancing diversity within medical school admissions including characterizing diversity with limited attention to racial justice, leadership challenges, and an overemphasis of certain academic metrics. They also identified strategies for increasing diversity: incorporating racial justice into the institutional mission and changing the process of admissions to include mission-specific metrics. Importantly, they call for a quality improvement approach which would include strategies to create an inclusive climate and to ensure representation of those underrepresented in medicine (URiM) at all levels of the organization. These findings highlight the urgency of reforms in organizational processes in medical school admissions and the need for a well-funded research and policy agenda to identify, implement, support, and replicate the optimal strategies that can effectively address the drivers of the problem. To achieve meaningful improvements in racial and ethnic diversity, Ko et al[2] suggest that we must change the story, people, process, and organization of admissions.

One review provides several examples of how this coordinated approach can result in meaningful improvements in diversity and quality.[3] Narrative change has been shown to be helpful in making positive changes in diversity. For example, aligning institutional excellence with achieving diversity was a critical part of a comprehensive diversity initiative at the University of Michigan that led to marked improvements in racial and ethnic representation among students and faculty with no loss in academic quality.[3] This example also highlights that there is no inherent conflict between diversity and merit.

Ko and colleagues[2] found that definitions of diversity were often decoupled from the need to address racial injustice among participants placing these institutions in danger of reproducing, consciously or unconsciously, the negative racial structures and biases that diversity initiatives are meant to address. To see meaningful change, we must achieve "critical diversity" in medical schools.[4] Central to critical diversity is an understanding of societal discrimination and exclusion of social groups, and the necessity of comprehensive and sustained attention to parity and equity in representation and opportunity throughout all levels of the organization. This stands in stark contrast to a "colorblind diversity" that celebrates cultural difference without acknowledging inequities in

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societal power or access to opportunities, or a "segregated diversity" in which an organization may become more diverse overall, but dominant groups remain overrepresented as faculty, deans, and in other positions of power and influence within the medical school.[4] Critical diversity has been shown to be beneficial. One study of over 5000 doctoral programs at US research universities found that an increase in gender and racial and ethnic diversity among faculty and students was positively associated with departmental rankings.[4]

Ko et al[2] also indicate that improving racial and ethnic diversity calls for the examination of processes and elimination of those that are not aligned with stated organizational goals to advance diversity.[2] For example, participants indicated that an overemphasis on the Medical College Admission Test (MCAT) was a barrier to advancing diversity, equity, and inclusion in admissions. Structural racism undergirds observed differences in MCAT scores between URiM and non-URiM applicants.[5] A narrow emphasis on the MCAT leaves qualified applicants, many of which are URiM, outside of the profession.[5] Reforms that ensure the appropriate use of the MCAT in medical admissions with relevant weight given to other important predictors of success, is not only necessary for racial equity, but consistent with the stated values and missions of many medical schools. Doctoral programs in science, technology, engineering, and math have showed that this can be done successfully by shifting from a singular emphasis on the Graduate Record Examinations to also including other metrics that have been shown to predict success in graduate school (such as research experience, service to the community, adaptability, and leadership).[6]

Organizations can help or hinder progress in advancing diversity. The siloed nature of many diversity initiatives can lead to a decentralization that stymies meaningful progress and can render diversity practitioners frustrated, isolated, and burnt out.[7] We agree with Ko and colleagues[2] call for greater coordination in order to make meaningful positive changes in diversity, but additional resources are a prerequisite. The study found that overemphasis on the MCAT and other numerical metrics was partially due to convenience given the large volume of applications received. This highlights the reality that there are not enough people compensated and enabled to perform the many crucial aspects of the admissions process including recruiting, screening, interviewing, and selecting future physicians. Issues of uncompensated academic labor and the devaluing of faculty and staff in academics have been identified as diversity issues.[8] Financial investment is needed to create working conditions that support faculty and staff to engage in strategies to improve representation. Administrators must remember that faculty and staff's working spaces are their student's learning environments.[8] To achieve critical diversity and inclusive learning environments, medical schools must address issues of uncompensated labor within medical education in general, and in admissions in particular. If we do not, we are setting ourselves up to fail.

The description provided by Ko and colleagues[2] clearly suggests that medical schools can be social institutions in which racism can become institutionalized. However, it is important to acknowledge that medical schools can also be potent catalysts for change. Just as these influential social institutions can perpetuate racism, they can also use their influence to upend it through implementation and support of successful strategies, such as those noted here. We applaud Ko et al[2] for their research that has made the invisible visible—highlighting the barriers to advancing diversity in medical school admissions and envisioning ways to address them. Their study is a clarion call for an ambitious research agenda to follow their lead and further uncover the ways in which organizational policies, practices, and norms hinder critical diversity and can serve as an evidence base for medical school leadership on how to prioritize meaningful improvements in racial and ethnic representation. Ko and colleagues[2] have powerfully reminded us that there is much work to be done. They have also indicated that the needed changes are no longer a secret. The question we collectively face in medical education is: are we ready to do the work?

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Published: February 24, 2023. doi:10.1001/jamanetworkopen.2023.2291

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Conflict of Interest Disclosures: None reported.

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