Progress for Whose Future? The Impact of the Flexner Report on Medical Education for Racial and Ethnic Minority Physicians in the United States

Ann Steinecke, PhD, and Charles Terrell, EdD

Abstract

The publication of the Flexner Report in 1910 had an immediate and enduring impact on the training of African American physicians in the United States. The Flexner Report’s thesis, “that the country needs fewer and better doctors,” was intended to normalize medical education for the majority of physicians, but its implementation just 48 years after the Emancipation Proclamation obstructed opportunities for African Americans pursuing medical education and restricted the production of physicians capable of addressing the health needs of a nation that would grow increasingly diverse across the century.

This article provides a working definition of structural racism within academic medicine, reviews the significant physician workforce diversity initiatives of the past four decades, and suggests the most successful of these possess strategies common to addressing structural racism (community empowerment, collaboration, clear and measurable goals, leadership, and durable resources). Stymied by popular ballot initiatives, relentless legal challenges, and dwindling funds, current and future efforts to increase diversity in medicine must maintain a focus on addressing the active remnants of structural racism while they build on the broad benefits of diversity in education and medicine. Despite creative and tireless efforts, no significant progress in expanding diversity within the U.S. physician workforce can be made absent a national effort to address this enduring barrier in the collective social, economic, and political institutions. The centennial of the Flexner Report is an opportunity for the academic medicine community to renew its commitment to dismantling the barriers to diversity and improving medical education for all future physicians.


The Social Justice Imperative

The United States today is a very different place than it was in Flexner’s time. Some medical schools led early initiatives to build racial and ethnic diversity among their students and faculty well before the federal government and the profession...
mandated change. The Association of American Medical Colleges (AAMC) has acknowledged that its role in history has at times "[fallen] short of our ideals" and is now a recognized stalwart in advocating for the benefits of diversity in education.3 Other professions look to medicine for guidance in replicating the successes we have achieved through diversity-building programs and policies. Still, after 30 years of effort, we are often confronted with the startling realization that we have made very little progress in expanding the cadre of racial and ethnic minority medical school graduates.

In 1968, 130 African American physicians graduated from U.S. medical schools.4 Four decades later, 1,109 African American physicians graduated from U.S. medical schools, a nearly ninefold increase.5 Beneath the surface of these numeric increases, however, are disturbing trends. In the past decade, the pattern of increase has stalled at an average of 1,133 African American medical school graduates (7% of total graduates each year).6 Meanwhile, the proportion of African Americans in the U.S. population (12.8% in 2008) continues to rise.7 How is it possible, people rightly ask, that the proportion of African American physicians to African Americans in the U.S. population is now actually lower than it was in 1910 (2.2% versus 2.5%, respectively)?

Too often, the assumption is that these efforts have been ineffective. More recently, and ironically, efforts to build racial and ethnic diversity have been attacked for diminishing the opportunities available to white9 and Asian American students.10 And, with the election of the first African American president, we now face changing expectations that our society has entered a "postracial" era. The day after the presidential election in 2008, Joe Klein11 described a new racial climate in the United States as "a place where the primacy of racial identity—and this includes the old, Jesse Jackson version of black racial identity—has been replaced by the celebration of pluralism, of cross-racial synergy." We posit, however, that mistaken optimism can easily undermine perceptions of the necessity for diversity building efforts.

It may be impossible to quantify the impact segregation has had on the quality of medical education in the United States and on the health of the nation. The Institute of Medicine’s report, Unequal Treatment, links the devastation of racial and ethnic disparities in health care to "the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life."12 Research on how educational disparities affect the country’s competitiveness in the global marketplace has now emerged along with research on the benefits of diversity to improving the education and health of all.13-15 In their recent article on the ethical foundation of medicine, Kirch and Vernon16 observe, "It seems that the structure of incentives in the current health system stimulates behavior that marginalizes considerations of social justice, leaving it seldom emphasized." So too, our flawed relationship to racial justice—both past and present—is inextricable from the inequities found in our current health system.

There remains much to learn about the century of organizing and educating, antagonizing and resisting, holding on and helping out that resulted in the successful reversal of legalized racial segregation in the United States. As the historian Gerda Lerner17(p2001) has cautioned, what we do about our history matters: "A meaningful connection to the past demands, above all, active engagement." As the nation’s demographics change dramatically over the coming decades, these lessons will be critical to ensuring we pursue focused, efficient, and effective efforts to accrue the educational and health benefits of diversity that will ultimately improve the health of the nation.

The Separate and Unequal Impact of Flexnerian Reform

To complete his report on the status of medical education in the United States, Abraham Flexner traveled the country to visit 155 medical schools. Often accompanied by N.P. Colwell, the secretary of the American Medical Association (AMA),18 Flexner conducted his expeditions regionally, visiting 26 schools in southern states in January and February 1909 before heading into the Northeast, the Midwest, and West later that year.19 The Flexner Report contains careful details of the variations in medical education he encountered. His report also contains subtle portraits of the country and its people. He observes "stranded small groups in an unpromising environment," and people "simply huddled . . . thickly at points on the extreme margin."20(p15) His equation for improvement and modernization—fewer, better trained doctors—was a repudiation of commercialized medicine. He argues,

The overwhelming importance of preventive medicine, sanitation, and public health indicates that in modern life the medical profession is an organ differentiated by society for its own highest purposes, not a business to be exploited by individuals according to their own fancy.21(p9)

Clearly, the highest aims of his reforms were to improve the health of the people he had encountered.

As many of the articles in this centennial issue demonstrate, elevating medical education from an unfettered commercial enterprise to a regulated professional degree strengthened the overall health of Americans. At the turn of the century, however, inequalities in access to and quality of health care were extreme for African Americans. Apart from charity hospitals and those established by the Freedman’s Bureau, access to modern health care did not exist. In large part, the relative proliferation of for-profit medical education for African Americans was directed at this need. However, for Flexner, who championed the closing of all for-profit medical schools as essential for improving the overall quality of medical education, standards for the benefit of the majority trumped nuanced strategies for the benefit of African Americans. Again, African Americans would be left to bear the weight of inequity. Flexner writes,

Pending the homogenous filling up of the whole country, inequalities must be tolerated. . . . The question is, then, not merely to define the ideal training of the physician; it is just as much, at this particular juncture, to strike the solution that, economic and social factors being what they are, will distribute as widely as possible the best type of physician so distributable.22(p13)

Symbolically, Flexner addresses “The medical education of the negro” in a separate, two-page chapter of his report (just as he separated his observations about women in medicine). Flexner
promoted the limited education of the African American doctor as a service to “his own race,” but also for the larger purpose of protecting whites from the African American population’s potential to spread disease:

The negro must be educated not only for his sake, but for ours. He is, as far as human eye can see, a permanent factor in the nation. He has his rights and due and value as an individual; but he has, besides, the tremendous importance that belongs to a potential source of infection and contagion.2(p180)

The basis of Flexner’s model for reform, that every medical school should be integrated into a university with a sufficient endowment and a university hospital, was a severe challenge for many schools.4 And although Flexner described a separate “mission” for African American medical schools, these schools were not exempted from demonstrating the same level of institutional resources that were expected of predominantly white medical schools. Flexner writes, “Make-believe in the matter of negro medical schools is therefore intolerable. Even good intention helps but little to change their aspect. The negro needs good schools rather than many schools.”2(p180) The financial requirements of a medical school, as Flexner estimated, were steep: “A university department in one of the fundamental medical sciences, none too elaborately provided, cannot then, on the average, be effectively maintained for less than $10,000 to $15,000 per annum.”2(p129) His estimate for the annual cost of maintaining a 200-bed hospital exceeded $150,000.2(p131) For the medical schools educating black physicians at the time (Table 1), the financial requirements alone were an impossible benchmark. When coupled with the organizational and educational requirements, most medical schools for African Americans were doomed. Flexner writes, “Of the seven medical schools for negroes in the United States, five are at this moment in no position to make any contribution of value to the solution of the problem.”2(p180)

Additionally, Flexner acknowledged that Howard University College of Medicine and Meharry Medical College were, “of course, unequal to the need and the opportunity,”2(p181) but neither the Flexner Report, nor the AMA, nor the AAMC provided plans to help these schools to achieve independent economic viability.20(p24–75)

The reform plan’s impact on the education of African American physicians, therefore, was predictably and drastically inequitable. Todd Savitt’s research documents how the combined requirements of the AMA’s Council on Medical Education (CME) and the Flexner Report forced the closure of all but two predominantly African American medical schools (Howard and Meharry) and severely limited the opportunities for African Americans seeking medical education.20(p73–74) There can be no doubt that these closures affected the size of the African American physician workforce in the 20th century. Race and ethnicity data compiled by the AAMC beginning with U.S. medical school graduates in 1950 show a total of 25,423 African American physicians graduating from 124 U.S. medical schools between 1950 and 1998. Of these physicians, 7,017 (28%) graduated from the three historically African American medical schools (Morehouse School of Medicine opened in 1978).21 Not accounting for variations in class size or the acceleration of diversity efforts after 1968, each of the remaining 121 schools graduated an average of just over three African American physicians per year during the same 48-year period.

For decades, African American students challenged Plessy v Ferguson, suing for the right to access state universities and graduate schools. These schools’ responses illuminate their commitment to enforcing segregation. For example, schools denying qualified African American students admission would offer to pay their tuition at schools out of state (as in the case of Lloyd Gaines and the University of Missouri School of Law) or open separate “programs” (as in the case of Heman Sweatt and the University of Texas School of Law).22 The University of Oklahoma constructed an “anteroom” complete with desk and chair to keep George McLaurin, a veteran teacher, separated from white students in the school’s graduate education program.22

In 1949, The National Medical Association (NMA) petitioned the AAMC to “issue a statement of policy to the effect that our medical schools should open to all without discrimination as to ancestry or religion.”23(p519) The AAMC’s Executive Council’s response was to maintain that it never “interfered with the admission policies of any of its member colleges.”23(p519)

<table>
<thead>
<tr>
<th>School</th>
<th>Location</th>
<th>Date founded</th>
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<tbody>
<tr>
<td>Howard University School of Medicine</td>
<td>Washington, DC</td>
<td>1869</td>
<td>Remains open</td>
</tr>
<tr>
<td>Meharry Medical College</td>
<td>Nashville, TN</td>
<td>1876</td>
<td>Remains open</td>
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<tr>
<td>Leonard Medical School of Shaw University</td>
<td>Raleigh, NC</td>
<td>1882</td>
<td>1918</td>
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<tr>
<td>National Medical College</td>
<td>Louisville, KY</td>
<td>1888</td>
<td>1912</td>
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<tr>
<td>Flint Medical College of New Orleans University</td>
<td>New Orleans, LA</td>
<td>1889</td>
<td>1911</td>
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<tr>
<td>Knoxville Medical College</td>
<td>Knoxville, TN</td>
<td>1900</td>
<td>1910</td>
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<tr>
<td>Medical Department of the University of West Tennessee</td>
<td>Memphis, TN</td>
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sprout confirm her preference for the red flowers, and over time that preference is transformed into a belief that red is better than pink. Jones explains the key elements that characterize institutional racism:

There is the initial historical insult of separating the seed into the two different types of soil; the contemporary structural factors of the flower boxes, which keeps the soils separate; and the acts of omission in not addressing the differences between the soils over the years.²⁴(p1214)

Jones argues that recovery must address the structural factors: “We have to break down the boxes and mix up the soil, or we can leave the two boxes separate by fertilizing the poor soil until it is as rich as the fertile soil.”²⁴(p1213)

Medical education after Flexner looked very much like the parable of the separate flower boxes. Medical education at predominantly white institutions flourished with unprecedented innovation and growth. Meanwhile, although Howard and Meharry offered medical students solid educations, they constantly struggled to survive. Down the pipeline, the academic preparedness of African American students was hampered by inequities in K-16 education. Up the physician-education continuum, African American physicians were barred from membership in professional societies and were denied opportunities to continue learning and assuming leadership positions. Medical school faculties remained white. And, these predominantly white institutions became the standard by which quality and prestige were measured. Ironically, we now know that the education of all physicians was stunted, for very few physicians received their training in diverse educational environments. Ultimately, however, it was patients of color who bore the brunt of these shortcomings. The Rev. Dr. Martin Luther King²⁵ observed, “Of all the forms of inequality, injustice in health is the most shocking and the most inhumane.” Segregation became a health disparities dynamo.

Two Americas meant separated health care, separated medical education, and separated professional organizations. Forty four years would pass after the Flexner Report before the Supreme Court would rule that separate was not, in fact, equal (Brown v Board of Education, 1954), and yet another 15 years would pass before the AAMC committed itself fully to ensuring African Americans, and all minority students, have equal and meaningful access to medical schools (Figure 1).


In 1954, based largely on precedents set by the Supreme Court cases of the men

²⁴ In 2001, the Institute of Medicine published The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in the Health Professions, a summary of the Symposium on Diversity in Health Profession in honor of Herbert W. Nickens, MD, first vice president and director of the Division of Community and Minority Programs at the AAMC until his death in 1999.
described above, lawyers from the National Association for the Advancement of Colored People (NAACP) succeeded in persuading the Supreme Court to overturn *Plessy v Ferguson*. The Supreme Court’s decision in *Brown v Board of Education* and the Civil Rights Act of 1964 initiated the requirement that universities—and medical schools—comply with desegregation. The decades of determined educational and professional segregation, however, and the delay resulting from some institutions’ interpretation of the language, “all deliberate speed,” culminated in a momentum for segregation that has not been swiftly or simply reversed.22

Early efforts to diversify U.S. medical schools

Anticipating the Supreme Court’s decision in *Brown v Board of Education* and the passage of the Civil Rights Act in 1964, the AAMC began seeking ways to promote integration in medical education. In 1968, the AAMC joined with the AMA to “endorse the position that all medical schools should now accept as a goal the expansion of their collective enrollments to a level that permits all qualified applicants.”26 The AAMC also began to collect information from its member schools about efforts at medical schools to enroll racial and ethnic minority students, which it published (and continues to publish) in *Minority Student Opportunities in United States Medical Schools*. Entries in the first edition ranged broadly in commitment and sophistication; with some schools reporting no special programs while others describe fairly extensive initiatives that include summer enrichment activities for high school students, outreach and recruitment at historically African American colleges and universities, inclusion of African American faculty on admissions committees, as well as financial and academic support. Many of the self-reports share the observation that the applicant pool was woefully insufficient, as in the example described below:

During the past several years, our applicant pool has expanded from eleven hundred to thirteen hundred, including no more than eight to twelve applicants who are known to be black. These applicants largely are very poorly prepared to compete in this medical school of known high standards; hence, our enrollment of black applicants has been disappointingly small.

To attempt to enlarge the pool of applicants we have searched diligently among the students of the predominantly black colleges and find that premedical students there are very scarce.

Lately we have visited the largely black high schools of the City of Houston in search of high school seniors who elect medicine as the progress to college. In this city of 1.6 million, our diligent search turns up less than twenty persons who will be premedical students in college. This critically small pool of possible applicants projected during the next several years has induced Baylor to prepare several activities of a recruitment nature designed to increase the pool beginning at the junior high school age. However, despite extensive efforts to recruit, support, and foster medical education in the black minority we are pessimistic about prospects for early improvement statistics of black med students.27(p5)

At about the same time, medical schools, with the help of the AAMC, began exploring ways to strengthen the admissions process to broaden consideration of medical school applicants’ preparation for medical school and their potential for success. These nascent steps towards what is now called holistic review involved a series of workshops called the Simulated Minority Admissions Exercise (and later the Expanded Minority Admissions Exercise) that prepared medical school admissions panels to identify students’ noncognitive strengths (e.g., altruism, leadership abilities, etc.).

Attention to the admissions process required a simultaneous exploration of the role of educational disparities and racial stereotyping in the disparate outcomes of students’ performances on outcomes on standardized tests, such as the Medical College Admissions Test (MCAT). Since first being administered in 1928, aptitude testing for medical applicants has gone through five eras, and the current version of the MCAT is now undergoing comprehensive review as well. Leaving aside the substantial literature demonstrating and discussing the predictive validity of the MCAT, it is important to acknowledge that testing and considerations of test scores by admissions committees began during a period of U.S. history when academic preparation and expectations were highly affected by racial segregation and stereotypes. Medical school admissions committees, facing an increase in their applicant pools and growing competition for admissions to highly selective institutions, relied increasingly on the MCAT as a tool in admissions decisions. As McGaghie26 notes, “Enlightened MCAT design and development was not necessarily matched by enlightened interpretation and use of MCAT scores for medical school admission decisions.”

Early challenges

Extensive outreach and pipeline initiatives, including affirmative action that focused on population parity, and attention to admissions processes were the dominant mechanisms for increasing diversity in medical education in the 1970s and 1980s. Although application data demonstrate progress (Figure 2), the efforts to rapidly increase diversity at the nation’s medical schools were anemic in the face of the complexity and enormity of the disparity. Writing in 1968, W. Montague Cobb,29(p331) president of the NMA, anticipated the severity:

In the past two decades, despite such efforts as have been made to recruit Negroes for medicine, there has been no significant increase in the number of applicants. Every year the problem grows worse because population goes leaping ahead while production of trained personnel creeps behind on an even smaller percentage basis. Obviously we deal with a massive problem which calls for massive remedy. All the Establishment has been able to show thus far is a massive, myopic incompetence.

After a further 20 years of efforts, progress became the target of anti-affirmative action backlash due to what Marta Tienda30 calls “the confluence of two master trends beginning in the mid-1970s, namely rising wealth and income inequality and rapid ethno-racial diversification of the school-age population.” Affirmative action was met with legal challenges and the ambition of expanding enrollment struggled with financial aid cuts and rising tuitions.

The first legal challenge to affirmative action to reach the Supreme Court was filed in 1974 by Alan Bakke, who was denied admission to the University of California, Davis School of Medicine. The Supreme Court’s decision in his case four years later struck down the school’s
two-track admission process that reserved a specific number of spots for minority medical students, but the ruling also preserved the right of schools to consider race and ethnicity in “appropriately circumscribed ways (‘narrowly tailored,’ in legal terms) to promote the educational benefits of diversity.” The challenge was significant, as well, because it garnered substantial publicity and schools across the country increased their awareness of their rights as well as their potential vulnerability to legal challenges to their admissions practices.

Commitment and infrastructure


After an initial spike in minority student enrollment following early efforts to diversify medical schools, minority student enrollment had plateaued at approximately 10% (Figure 2). The new national initiative was intended to link short-term strategies and individual schools’ efforts with a long-term strategy to build the pool of qualified underrepresented minority students interested in careers in medicine. Project 3000 × 2000 focused on creating partnerships, articulation agreements, curriculum enrichment in high school and college, tracking, and targeted outreach. As Project 3000 × 2000 continued to address academic preparation and outreach, at its heart was the recognition that, in the absence of firsthand knowledge of what it takes to prepare for a career in medicine, it is very difficult for young people to transform their abstract hopes of becoming a doctor into a concrete plan to achieve this goal.

A chief innovation of Project 3000 × 2000 was its move away from population parity goals and toward supporting changes in medical schools’ educational environments and relationships with community in ways that would reduce barriers to access and improve interest in careers in medicine among minority students.

Still, medical schools’ efforts continued to be stymied by ballot initiatives, lawsuits, and legislation. In 1996, California voters passed Proposition 209, which outlawed considerations of race and ethnicity in admissions to the state’s institutions of higher education. Washington (1998), Michigan (2006), and Nebraska (2008) have since followed suit. In the same year that Californians passed Prop 209, a ruling by the Fifth Circuit Court outlawed affirmative action in Texas, Louisiana, and Mississippi. And, in 1999, then Florida Governor Jeb Bush began the “One Florida Initiative” that outlawed affirmative action at the state’s universities and in public hiring. In less than a decade, medical schools in three of the country’s most populous states (California, Texas, and Florida), of which two have minority-majority populations (California and Texas), lost the ability to consider a student’s race among the array of factors they consider of value when composing their medical school classes. Despite an array of initiatives across the country, medical schools could not maintain their early progress in achieving diversity. In fact, the 1990s saw efforts in some key states severely curtailed.

The benefits of diversity

The most current efforts to diversify medical school enrollment have been informed by the legal arguments resulting from the backlash against affirmative action. In 2003, the Supreme Court ruled...
on a case brought against the University of Michigan (Grutter) that challenged the ability of the law school to include considerations of race and ethnicity in its admissions policies. The court upheld that

the educational benefits that the university sought to achieve through student body diversity—improving teaching and learning, enhancing civic values, and preparing students for a twenty-first century workforce—were, indeed, "substantial," "real," and "compelling."31(p3)

In doing so, however, the Supreme Court supported a broad and inclusive definition of diversity. If such diversity rises to a compelling interest for a school, then the school is permitted to use narrowly tailored considerations of race and ethnicity within its efforts to achieve the benefits of diversity. The AAMC’s Holistic Review Project is building a repository of resources and training materials that will empower medical schools to create and sustain multidimensional diversity initiatives that enhance the “teaching and learning for all students and establishes foundations for more expansive, quality medical care in all communities.”33(p v)

Understanding History and Transforming Culture

To this day, the effort to desegregate medical education—and ultimately to encourage diversity to thrive—has been shaped by the racial history of the United States, Flexner’s reform of medical education within that context, and our evolving ability to recognize and counter the complex and intricate vestiges of segregation in the process of medical education and health care. Recently, organized medicine has begun a frank examination of its history in order to better tell the full story of the challenges encountered when changing the face of medicine. Exploring racism and the AMA, Baker et al observe, and we agree, that “History rarely offers simple moralist tales.” They rightly note that, in spite of his recommendations’ disproportionately negative impact on African American medical education, “Abraham Flexner ultimately became a strong advocate for Howard and Meharry medical schools.”34(p17)

The historical consequences of reform cannot and should not be laid at the feet of Abraham Flexner; instead, they result from medical schools, universities, and teaching hospitals implementing standards informed by overt and covert social norms shaped over centuries. We argue these standards form what Edgar Schein describes as organizational culture:

a pattern of shared basic assumptions that was learned by a group as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems.

As medical schools took steps to align their curricula, university and teaching hospital relationships, and financing to Flexner’s criteria, the culture of professional education of physicians was simultaneously ordering

a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group equity . . . allow[ing] privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time.35(p11)

The work of undoing this has been to cultivate students and faculty, administrators and admissions committees, leaders at every stage of medical education who are capable of addressing what John Hope Franklin describes as “the subtleties and the sophistication that characterize the maintenance of the status quo.”36 And, in as much as medical education has continued to produce a cadre of physicians and educators who are dedicated to this effort, it has been successful, despite not yet celebrating true equity of opportunity.

Keys to Diversity

We have learned a great deal from efforts within medical education to remedy segregation. The earliest efforts attempted to introduce change in the student body without radically changing the institutional model of medical education. Schools introduced greater numbers of African American medical students (and other students of color) abruptly rather than examining the assumption that desegregation required a simple numerical shift in enrollment rather than a thorough overhaul of institutional climate and structures. According to Dr. Jones’ analogy, these early efforts were the equivalent of mixing the seeds without preparing the soil. As the first Minority Student Opportunities in U.S. Medical Schools publications show, the results were problems with a limited applicant pool, disproportional attrition rates, and suspicion of the minority medical students’ qualifications rather than a belief in the integrity of the medical education programs preparing all future physicians to care for an increasingly diverse population.

Success in building a physician workforce that is racially and ethnically diverse (and ultimately reflects the spectrum of human difference) will require continually transforming the institutions that serve as a gateway to the profession. We believe history supports five enduring keys to success: consistent funding, exacting data collection and innovative research, constitutional mission-based diversity policies, community engagement, and outspoken, daring leadership.

Consistent funding

Within the context of Flexnerian reform, lack of funding was one of the primary reasons for the medical school closures represented in Table 1. Savitt reports the president of Flint Medical College blamed the closure of that school on “the CME’s increasingly intense campaign for improved standards, and the school’s lack of money to make the necessary changes.”20(p74) While the historically African American medical schools lacked endowments and struggled financially throughout the century, there was little need for majority schools to dedicate resources to diversity efforts. A small federal allocation and philanthropic contributions from the Freedmen’s Aid Society, the National Medical Fellowships, Inc., the Carnegie Foundation, and others, allowed Howard and Meharry to survive. Resources to jumpstart diversity initiatives also came from outside the institutions themselves, such as the Macy Foundation and National Medical Fellowship’s partnership to host the 1967 Conference on Negroes for Medicine, the Office of Economic Opportunity’s funding of the publication of Minority Student Opportunities in United States Medical Schools, and early federal funding through Title VII for Centers of Excellence and Health Careers
Opportunities Projects. Funding generated within individual medical schools for diversity initiatives, however, has been difficult to sustain, particularly in times of economic difficulty. The commitment to change the face of medicine requires the commitment of funding sufficient to ensure success.

Exacting data collection and innovative research

Dr. Cobb[^2][p322] recounts the career of Ambrose Caliver, PhD, who worked in the Department of Health and Welfare as the first Specialist in Negro Education. Appointed in 1929, Dr. Caliver assembled and had published educational data covering every aspect of what the Negro was getting and not getting. He engineered a conference after conference of appropriate people on problems in the education of Negroes. He fought for space in the news media and time on the air to get his story to the public. At the official request of the U.S. Supreme Court he supplied information and interpretations from his unmatched background and experiences, which the court used in arriving at its historic decision of May 17, 1954, holding segregated schools to be unconstitutional.

Dr. Caliver’s work, culminating in the reversal of segregated schools in the United States, exemplifies the power of continuing research on race and ethnicity in education. The collection of race and ethnicity data on medical school applicants, matriculants, and graduates has evolved significantly over time—from culling through medical school yearbook photos and estimating certain demographics based on surnames to building longitudinal databases for tracking students’ progress through and experiences with medical education. Social science research has also contributed extensively to diversity efforts. Work by Steele and Aronson[^3] has helped educators understand the powerful effect of stereotype threat on students’ performance on standardized tests. Recent organizational research has branched into examinations of the value of diversity in social groups, such as the workplace, community organizations, etc.[^4] And, research specific to medical education has demonstrated the benefits of diversity that accrue to all students.[^5][^14] The ongoing collection of accurate data and the expansion of research on diversity in the medical education setting are invaluable to shaping and evaluating the impact of programs and policies.

Constitutional mission-based diversity policies

The pursuit of racial and ethnic diversity in medicine began before Brown v Board of Education, but the landmark ruling enforced the civic responsibility of desegregation in education. In his foreword to Roadmap to Diversity, John Prescott, MD, then dean of West Virginia University School of Medicine, writes,

In that diversity is a compelling interest for our institutions, each of us has a civic, professional, and legal responsibility to our fellow citizens to support the diversity efforts at our schools. Together, we must make building diversity a coherent effort in which administrators, faculty, students, and legal counsel are all engaged.[^3][^15]

Writing for the majority in Grutter, Justice Sandra Day O’Connor observed that the compelling interest may last for merely another 25 years,[^9] which many have interpreted to be a sunset clause. What initiatives like the AAMC’s Holistic Review Project seek to emphasize is the enormous value to schools in understanding the rights and opportunities that remain open to them for pursuing race-conscious diversity efforts within the context of achieving the educational benefits of diversity—including racial and ethnic diversity—that accrue to everyone in the medical education setting.

Community engagement

At the heart of Project 3000 × 2000 was an awareness that the barriers that inhibited minority patients from access to care were similar to those inhibiting minority students from participating in mentoring and learning experiences to encourage their pursuit of medicine. Historically, the relationship between medical schools and minority communities has been clouded by feelings of distrust, with major medical research institutions residing along side communities experiencing serious health disparities. Since the earliest publication of Minority Student Opportunities in U.S. Medical Schools, however, there are clear examples of how crucial community engagement initiatives are to building a diverse and qualified medical school applicant pool. In fact, community outreach in the form of academic enrichment activities for local students, teachers, and community leaders is now a nearly universal feature of U.S. medical education.[^39] From 1996 to 2005, the Robert Wood Johnson and W.K. Kellogg Foundations funded the Health Professions Partnership Initiative, which linked 26 medical schools with universities, colleges, K-12 public school systems, and local communities on projects to improve curricula and provide hands-on learning activities that would introduce school children to the possibility of careers in medicine, improve their academic preparation, and strengthen collaborations between communities and medical schools.[^40] And, because much of medical students’ clinical education occurs in community ambulatory clinics, there are important examples, such as that by Michener et al[^41] at Duke University Medical Center and Health System, demonstrating how community–institution engagement both addresses disparities and engages local students in opportunities that promote careers in medicine.

Outspoken, diverse, and daring leadership

Few movements in U.S. history have produced the caliber of leadership, both national and local, as did the Civil Rights Movement. For medicine, there is no finer example from that era than W. Montague Cobb, MD, PhD, who served as president of the NMA and the NAACP. Dr. Cobb’s advocacy for change was clear-eyed and adamant. In 1957 he wrote,

In the medical area too, all the proposals of separatism, gradualism, appeasement, compromise and indifference have been tried, so that any approach today which is lacking in candor or smacks of reservations, is viewed with suspicion and fails of public confidence.[^42]

The leadership of academic medicine today is outspoken in its decades-long commitment to building diversity in medicine. More important, this leadership has led to clear standards[^45] and mission-based approaches that pursue diversity as a fundamental criterion of achieving excellence in medical education.[^31][^39] As powerful as these changes have been, however, the leadership of academic medicine—and the faculty from which it is drawn—continues to suffer from a lack of diversity (see Figure 3). The benefits that
Darrell G. Kirch, MD, wrote, “If discrimination and segregation continue our work toward building diversity—both racial and ethnic diversity and diversity across the broad spectrum of human difference—for the benefit of medical education and health. This history has shown that a focus on applicant and matriculant numbers alone will obscure the tremendous transformation the nation’s medical schools have achieved with regard to racial and ethnic diversity. It has also shown that future success depends on, at minimum, five criteria: funding, research, community engagement, mission-based goals, and leadership. Finally, this history demonstrates that the work of reform—with our current focus on expanding the physician workforce, an increasingly globally diverse population, and mounting pressure to transform health care delivery in the United States—is as relevant today as it was 100 years ago. In important ways, we must do more than accept accountability. I think we now have the unique opportunity to engage in the type of institutional self-reflection that not only will strengthen our commitment to diversity, but guide us in our future decision making.”

Recalling racial segregation and exploring its impact on medical education is a necessary and valuable component of the Flexner Centennial. Without acknowledging generations of discrimination and the institutional structures developed to support it, we lack the understanding needed to continue our work toward building diversity—both racial and ethnic diversity and diversity across the broad spectrum of human difference—for the benefit of medical education and health. This history has shown that a focus on applicant and matriculant numbers alone will obscure the tremendous transformation the nation’s medical schools have achieved with regard to racial and ethnic diversity. It has also shown that future success depends on, at minimum, five criteria: funding, research, community engagement, mission-based goals, and leadership. Finally, this history demonstrates that the work of reform—with our current focus on expanding the physician workforce, an increasingly globally diverse population, and mounting pressure to transform health care delivery in the United States—is as relevant today as it was 100 years ago. In important ways, we are wiser and better prepared for the future.

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25 King ML. Presentation at the Second National Convention of the Medical Committee for Human Rights; March 25, 1966; Chicago, Ill.


