EDITORIAL

Diversity in Medical Schools—Need for a New Bold Approach

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In this issue of *JAMA*, Montgomery Rice details the wrenching history of Black men and women and medical education and the many challenges still thwarting the long-standing goal of increasing diversity in US medical schools.[1] From her purview as dean at Morehouse School of Medicine, she offers unique insights and specifically illuminates the failure to increase the enrollment of Black medical students, especially at new medical schools, many of which have explicitly adopted diversity as a foundational pillar of contemporary mission statements. As a consequence, the medical schools serving historically Black colleges and universities (HBCUs) carry an outsize role in training Black medical students, but true diversity continues to lag. A different model is needed to fully address diversity in medicine.

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In a recent report in *JAMA Network Open*, Campbell et al[2] evaluated the legacy and consequences of the Flexner Report, which prompted closure of 5 Black medical schools at a time when strict segregation forbade admission of Black students to most other medical schools. Black men and women were nearly completely expunged from medicine. The consequence of those closures substantially reduced any meaningful capacity to educate Black men and women as physicians and led to an estimated deficit of approximately 30 000 Black physicians over the past century through 2019.[2]

In the 2019-2020 academic year, 21 863 first-year medical students were enrolled in the US, including 1626 Black medical students (7.4%), of whom 62% were women and only 617 (2.8%) were men—a number that has been stagnant since 1978.[3] These metrics are halting; no ideal threshold qualifies as the goal for percent diversity to achieve, and quotas are unacceptable, but the current representation is clearly insufficient and fails to fully serve the population, especially at-risk communities.

As noted in the Viewpoint by Montgomery Rice, Medical College Admission Test (MCAT) scores remain the most important gatekeeper for admission to medical school. A base requirement for the requisite aptitude needed in medical school should be unwavering, yet a more holistic assessment of measures of success argues that skills and attributes not captured by MCAT scores may well associate better with success as a physician. Moreover, the precious separation of medical school rankings by fractions of a point drives an emphasis on those metrics that are most readily modifiable, particularly the threshold MCAT score for medical school admission. The current system as configured, despite the important contributions by the 4 mostly Black medical schools and the persistent laudable diversity and inclusion efforts by other medical schools, with some notable successes, will continue to fail as solutions to achieve meaningful diversity in medicine. True diversity will require a significant increase in capacity and a bold and different approach.

How can capacity be increased? The recent welcomed magnanimous gift of $100 million to these same Black medical schools assuages student debt but will not add capacity or increase diversity.[4] Were each established medical school able to increase by *one* the number of Black or underrepresented minority medical students, capacity gaps would be narrowed (and such an initiative ought to be considered). An alternative approach would be to establish a new medical school, *specifically* at an HBCU. Why an HBCU? These institutions have a legacy of nurturing raw talent, piercing negative inertia, and illuminating arcs of success. The current 4 medical schools in part aligned with HBCUs and serving Black medical students represent 2.6% of total medical schools yet account for 15% of all Black medical students.[5] Many HBCUs without a medical school have exemplary academic metrics and would be excellent candidate institutions, particularly in partnership with already established medical schools, premier medical centers, and historical safety net hospitals. It is this model that has enabled the success of Morehouse. This new medical school concept provides a needed near-term solution that definitely enhances capacity and, when added to the ongoing commitment to increase diversity in existing medical schools, amounts to real change.

The costs associated with starting a new medical school are considerable, but funding alone is absolutely not the major challenge. Over recent months, academic medical centers, large hospital systems, and industry leaders in pharmaceutical and device therapies have offered compelling statements expressing a shared strident resolve to address health equity, promote antiracism, and improve diversity. Converting those implied commitments into capital contributions plus philanthropy (the endowments of many foundations have reached record levels) could easily sum to an estimated $200 million to establish a new medical school. For many of these enterprises, an investment of $1 million is a rounding error on the balance sheet; a goodwill investment in keeping with a not-for-profit status; or only a fractional assessment against a multibillion-dollar endowment. The aggregate amount may be daunting, but it equates to only one-fifth of the usual costs associated with the successful discovery, research, and marketing of a single cardiovascular therapeutic.

The comparative return on investment once a new medical school is established is inestimable—more physicians to care for an increasing aging and more diverse population; more

diversity in medicine; greater investment in targeted communities; and the greater good of more mentors, role models, and medical leaders of color. Considering the journey through unmitigated health inequities that medicine has endured in 2020 and the call for change in 2021, is it not the moment for diversity to "roll down like waters"? The solution is actionable, affordable, and potentially transformational.

Over the past century, a litany of affronts—the Flexner Report, racism, sexism, segregation, selective admissions policies—have impeded the entry of not just Black individuals in medicine but other underrepresented minority groups, including immigrants, Jewish persons, and women (although women now represent more than 50% of first-year medical students and many Jewish persons have found a welcoming home in medicine). If the US continues along this path, there is no iterative series of changes that will ever fully address the deficit representation of minorities in medicine; the US will remain mired in insufferable health inequities. If intentions are sincere, a new disruptive approach is clearly needed. Much like the lingering effects of redlining in Black communities, the lingering effect of the Flexner Report requires repudiation and repair.

Some will steadfastly oppose this model given the intent to increase the number of Black individuals in medicine; others will declare this model is not executable, if only because of cost; and still others will say it does not go far enough. However, it is absolutely clear that increasing the number of physicians that represent the communities they serve is the right and just thing to do. To date, it is the path not taken, and the best assault on health inequity. The need for this bold new approach is compelling and convincing, and the dollars are available. The only question is whether the necessary will can be summoned to begin the long-overdue process of achieving diversity in medicine.

ARTICLE INFORMATION

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