Episode – **Ethics Talk: *Myths of "Merit-Based" Admissions***

Guests: Jewel Mullen, MD, MPH, MPA and Dave Henderson, MDs
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[bluesy funk theme music]

TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. And when we say admission is merit-based, what do we mean? When it comes to medical school admissions, we might expect that applicants who are best qualified get in, but best qualified doesn't really tell us much more than merit-based did. To many, it might suggest good academic performance and good scores on standardized tests like the MCAT, the Medical College Admission Test. Based on data from the Association of American Medical Colleges, first-year medical students' advancement to their second year was correlated with those students' MCAT scores and their undergraduate grade point averages. When medical students become physicians, however, their MCAT scores don't really correlate at all to how well they practice medicine. So, that might lead some to ask, why do we place so much emphasis on medical school applicants' grades and test scores at all if neither of those things suggest what kind of clinician they'll actually end up being? Who cares if they do well during four years of medical school if what matters is the quality of their medical practice over the course of their careers, how collegial they are, and how well their patients and communities do under their care?

Workforce diversity and inclusion are critical to motivating equity and health outcomes, health status, and access to health services. Building a health care workforce that's diverse in all the ways that patients are diverse—racially, ethnically, in terms of ability and gender, and many other ways besides—is perhaps as much about merit and academic performance as it is about emotional intelligence, compassionate motivation, and persistence. Since those kinds of traits don't come with a score in a prospective student's application, holistic review of candidates is essential to making sure we focus on finding individuals committed to health justice and willing to not just become good students, but good clinicians with whom colleagues and patients want to work.

This month's issue, *Health Justice and Diversity in Medical School Admissions*, explores how we should pursue diversity and inclusion as key educational and professional priorities in medicine. Joining me on this episode of *Ethics Talk* to discuss this question are the Senior Editorial Fellows who helped build this issue, Dr Jewel Mullen, Associate Dean for Health Equity at the Dell Medical School and Associate Professor in the school's Population Health and Internal Medicine Departments, and Dr Dave Henderson, Professor and Chair in Family Medicine and Associate Dean for Multicultural and Community Affairs at the University of Connecticut UConn Health. Doctors Mullen and Henderson, thank you so much for being here.

DR DAVE HENDERSON: Thank you.

DR JEWEL MULLEN: Thank you for having us and for this conversation.

HOFF: Questions that many might have about our theme issue this month about justice and diversity in medical school admissions are things like, “The best applicants just get admitted, right? Why does it need to be more complicated than that?” How might you respond to someone coming to this conversation with those kinds of questions?

HENDERSON: That’s an interesting question. I think the important element of that question is “best.” And I think that’s a word that’s always used. We hear about the best applicants. We hear about the most qualified applicants.

HOFF: Mmhmm.

HENDERSON: But when you ask specifically sort of what is meant by that, sometimes the answers are not terribly precise.

HOFF: Mmhmm.

HENDERSON: And I think that what underlies that question, and the perspective that’s necessary to answer it well is, what’s the purpose of medical education to begin with? Is a primary goal to educate a workforce that is capable of meeting the needs of our population? Or is this more to promote the sort of presumed merit of given individuals? And I think depending on how one responds to that question generally provides some insight into how “best” or “most qualified” is defined.

HOFF: Great. Thank you. And Dr Mullen, anything to add to that?

MULLEN: Sure. I’ll respond and add thinking about the themes of justice and diversity in medical school admissions and remind myself and others that the admissions process goes beyond just finding people who can get into medical school.

HOFF: Hmm.

MULLEN: But really, the purpose underlying that is to identify people who are going to go out and be the doctors that we need to serve society.

HOFF: Mm.

MULLEN: We don’t necessarily look at sort of the so-called objective criteria that some people might want to point to and say that’s how you define best and then know for sure what that translates into when we think about the clinicians, the practitioners, the researchers, the policy influencers, and others that become part of a physician workforce. So, it is more complex. And I want to add, as somebody who is a gardener or who has nurtured things, our society helps create certain fallacies about best depending on how we nurture things that we’re responsible for.

HOFF: Hmm.

MULLEN: So, if we’re thinking about, once again, the hurdles or the hoops that people jump through in terms of standardized tests and GPAs, we are not nurturing learners in ways that everybody has the fairest opportunity to show what they’re capable of, so we should not sort people that way.

HOFF: A lot of the articles in this month's issue use the phrase "underrepresented in medicine." Can you explain what it means for a group to be underrepresented in medicine and why patients and their loved ones should care about what this means for the quality of health care?

HENDERSON: The groups who are underrepresented in medicine tend to be the same groups who are generally underrepresented in higher education. They tend to be the same groups that are underrepresented at the top levels of our socioeconomic structure. And that isn't necessarily by accident. I mean, I think to go back to something that Dr Mullen touched on just a moment ago, there are groups of people who experience educational inequities, and those inequities exist throughout the range of education in this country, beginning in grammar school, extending to secondary and undergraduate school. And those groups are educated unequally, and so they do end up being underrepresented by the time one gets to the population of students who enter medical school.

And from my perspective, the reason that it's important from a quality perspective is that the same groups who are underrepresented in medicine also experience health disparities. And we know that physicians from underrepresented groups are more likely to serve underrepresented populations. And there's a growing body of evidence that suggests that at a minimum, when you have congruity between patient and physician in underrepresented groups, that there is improved patient compliance, and in some areas, better patient outcomes. And this is an area I think that is just starting to be looked at carefully, but there are already significant benefits that've been documented in that congruity. And so, the underrepresented groups going forward do need to be better represented if we are to address the health disparities that exists here.

HOFF: Dr Mullen?

MULLEN: So, adding to Dr Henderson's points thinking about what representation means, I would encourage us to think about if we think about, we'll take the United States and the demographic makeup, the proportion of White, Black, Hispanic, Native American, and other groups in the country just in our general population, one might think, well, when I look at doctors, when I look at people in medicine, then the professions, the people doing that work would be present in similar percentages. And when we end up with, for example, 12 to 13 percent African Americans in the U.S. population, but only maybe three percent to four percent in the physician workforce, that's an example of underrepresentation. And even though I listed some rough statistics, I'm not trying to imply that we need absolute matching number for number, and if you get to that percentage, then you've done well enough. But we need to recognize when there are vast differences between who's in the general population and then who's present in any workforce.

HOFF: Mm.

MULLEN: And so, when we think about what it means to people who are accustomed to living in a society, and then they have to enter a realm like a health system and find that the people that they have to place their well-being and their trust in and people that they believe are going to understand them don't come from or aren't represented in the same kinds of proportions, it can become more than unfamiliar; it can become uncomfortable and disorienting. But it also challenges us to ask ourselves, why is it that way? So that underrepresented isn't just then about numbers, but it's about the systems that created those uneven distributions.

HOFF: Yeah, I think you touch on an important point here that creating equity in medical school admissions is more than just getting a certain number of applicants from groups who are underrepresented in medicine; it's helping to ensure that those students are in a position to apply in the first place. And then when they're admitted, that they're supported in an ongoing way and not just left to fend for themselves in an environment that is probably not welcoming to them. So, what are some examples of recruitment and retention initiatives taken by medical schools looking to meaningfully contribute to physician workforce diversity and inclusion? And Dr Mullen, if you want to take this one first.

MULLEN: So, I would say most, if not all—and Dr Henderson might be more specific than that—most, if not all, medical schools administer some programs, because of their commitment and perhaps because of accreditation standards, administer programs that are designed to make the pathways into medical education broader and more durable for students who are underrepresented, for students who may be in systems where the education isn't as high quality and their preparation, particularly in STEM, isn't as good.

In some places—and I saw examples of this at Morehouse School of Medicine—those programs start with early learners, say elementary school learners, and carry them through. So, there are examples of programs that will be at the elementary, secondary, and post-secondary level because they continue into college, but then to also assure that even students who might come into medical school with less confidence and lesser exposure to some of the science and math can still have other opportunities to keep bolstering and reinforcing their learning and confidence and sense of belonging even once they're there.

HOFF: Mmhmm.

MULLEN: I'm going to finish this point by saying I'm encouraged to see more attention being paid to the faculty behaviors and changes that also need to unfold to make learning environments better for learners because that's so important to retention.

HOFF: Can you give an example of something that maybe faculty are either being encouraged to do or perhaps discouraged from doing to create that environment?

MULLEN: So, where I work, for example, there's increasing focus on faculty mentorship of learners.

HOFF: Mm, mmhmm.

MULLEN: There's increasing focus on bystander training, not just bias training, but calling out where faculty behaviors and statements are actually polarizing and harmful, sometimes stigmatizing to students to create not, I wouldn't say necessarily zero tolerance policies, but to create the environment where those behaviors are pointed out.

HOFF: Right.

MULLEN: So that the support isn't just to make a student feel better, but to also keep shaping the environment.

HOFF: Sure. And to let other students know that it's not an environment where that sort of thing is tolerated or even just ignored.

MULLEN: Right.

HOFF: Dr Henderson, do you have anything to add?

HENDERSON: Yes, I'll just sort of start with something personal, which is that one of the motivations to enter an academic career for me, after spending two decades in community-based practice, was the realization that at every stage of my education, in every program that I was in from secondary school onward, there was someone who looked like me who did not complete the program. And in many of those cases, it was clear to me that those people were not lacking any cognitive skills. And in many cases, I think many of them were smarter than me. But what...but the barriers they faced were not intellectual or cognitive; they were very much cultural and social.

HOFF: Mmhmm.

HENDERSON: And so, diversity is one thing. And the sort of typical metaphor is diversity is being invited to the party. Inclusion is being asked to dance.

HOFF: [chuckles]

HENDERSON: I think that there is a good deal of focus on diversity, which is good, but not as much on inclusion. And I think inclusion is in many ways a lot more challenging because it's more difficult to measure. But it's important that we do focus on inclusion because in the absence of that, we end up with increased rates of attrition, which undermine the effort that diversity represents.

HOFF: Yeah. Thank you for clarifying the difference between diversity and inclusion there. I think that's an important point that's often muddled or overlooked. It's also common for some to confuse the topics of diversity and inclusion in legal contexts such as affirmative action, for example, with the work of accreditation groups like the Liaison Committee on Medical Education, which works to develop standards, including diversity standards, that schools need to meet to maintain their accreditation. So, what should our listeners know about how legal and accreditation approaches to diversity and inclusion in medical education differ from each other?

HENDERSON: There are bodies that basically evaluate and provide accreditation to medical schools. The LCME is that body. There's another body that serves that same function with residency programs, and that's the ACGME. And both of those organizations have diversity as part of the assessment that they do of medical schools, sort of undergraduate medical education and graduate medical education. And so, that's sort of one level of evaluation and assessment. But it's not necessarily what most people see or know about or pay attention to when we think of things legal. And I'm certainly not a lawyer, nor do I aspire to be. But the legal issues related to efforts to improve diversity are longstanding in many cases and are frequently challenged also. And so, I think that the efforts vis-à-vis the accreditation bodies to push diversity are laudable, and I think that in general, they do a good job at tracking diversity. They may not be quite as adept at assessing issues related to inclusion, again, because they're much more difficult to measure.

The legal issues, I think, are in many cases more fraught, particularly in recent years with the backlash against affirmative action, which has actually sort of spread even to holistic review processes. And so, everything that's diversity related gets sort of painted with an

affirmative action brush, and it becomes, I think, difficult to actually communicate effectively and accurately the efforts that are being made by medical schools to promote diversity and to do so in ways that are fair and equitable.

HOFF: Mmhmm. Can you talk just briefly about what those holistic admissions policies sort of look like, for people who are unfamiliar?

HENDERSON: Yes, I think most schools now have some version of holistic review.

HOFF: Mmhmm.

HENDERSON: And there are other mechanisms that are used also, but specifically with holistic review, there is an effort to broaden the scope of assessment of applicants. And so, as an example, when I went to medical school, I mean, your GPA was important. In recent years, MCAT scores have been really important. But holistic review, I think, provides a much broader assessment of applicants to medical school, including assessing the applicant's background. There are metrics such as distance traveled, sort of where did this person's education start? Were they educated primarily in an under-resourced school system? And looking much more broadly at applicants than just at quantitative metrics in particular, which I think are not always representative of someone's overall skill and capacity to be an effective physician.

HOFF: Great. Thank you. Dr Mullen, did you have anything to add on this question of the differences between legal and accreditation approaches to diversity and inclusion?

MULLEN: Sure. In the accreditation sides, I really appreciate the detailed answer that Dr Henderson gave.

HOFF: Mmhmm.

MULLEN: So, as I think about the accreditation side as the framework or the standards that schools must meet and will be judged by to make sure that they are engaging in policies and practices, behaviors that promote diversity and retention, I think it's really important for people to—I'm going to do a "now hear this"—understand that affirmative action laws and policies are about what organizations, by law, should do and what they must no longer do.

HOFF: Mmhmm.

MULLEN: And the way I put it that way is because affirmative action laws really evolved as a reaction to centuries of discrimination and holding back of minoritized peoples and women. And so, affirmative action laws are really about no longer practicing those discriminatory acts, and creating environments that will actually make opportunities more accessible to those who have been discriminated against. Creating better opportunity for people doesn't mean someone else has to be discriminated against, though.

HOFF: Mm.

MULLEN: I hope I'm making that clear. And the reason I wanted to say that is because I have worked with people who have said that they believe affirmative action is reverse discrimination.

HOFF: Mmhmm.

MULLEN: It is not.

HOFF: Mmhmm.

MULLEN: But if affirmative action was laws were instituted to counter and eliminate, hopefully, discriminatory practice, by replacing those practices, that doesn't create reverse discrimination. It creates opportunities for a fairer system for others. And to be fairer, that means you have to recognize where barriers have been put in place, where people have suffered discrimination, where people have been held back, where people have not been viewed as equivalently capable, getting back to what best means.

HOFF: Mmhmm.

MULLEN: Affirmative action sort of eradicates this notion that we can line up a set of criteria that we call "best," that keeps favoring, in this country, White people and men in particular, or people who are not disabled.

HOFF: Mmhmm.

MULLEN: I'm going to stop and see whether or not I'm making Dr Henderson shake his head in disagreement or anything else. [chuckles]

HOFF: [laughs] Dr Henderson?

HENDERSON: I agree wholeheartedly. And I think that's really very well-articulated.

HOFF: Mmhmm.

HENDERSON: I think that when we look at affirmative action, one of the things that happened historically that people often don't talk about is that in the early '70s, when affirmative action policies really started to pick up, enrollment in medical schools actually increased substantially. So, as a result of affirmative action, there were more people from all groups who were admitted to medical school. So, the story that there were some people who were admitted and other people who were excluded is actually a false story.

HOFF: That's interesting.

HENDERSON: And there were significant increases among many populations. And in fact, between 1970 and 2002, the percentage of women physicians tripled from like 7.6 to just over 25 percent, and most of those women were White women. And in fact, the data demonstrate that if you look at who benefited most from affirmative action policies, arguably White women did. And that's a good thing because women were grossly underrepresented among physicians. But again, that isn't often part of the story that's told about efforts to diversify the population of physicians in this country.

MULLEN: Can I add one other thing?

HOFF: Absolutely, yeah.

MULLEN: I don't know whether the right term is that we need to be honest with ourselves, but I challenge all of us to consider whether or not someone who challenges affirmative action explicitly or implicitly, suggesting that people who are admitted in the context or in the existence of affirmative action policies did not deserve to be admitted when we've already sort of challenged what the notion of best is and are talking about not, at the end of the day, not just admissions, but having a high-quality physician workforce for our society.

HOFF: Mmhmm.

MULLEN: And so, challenges and questions about affirmative action are reminders that we still have a way to go in the way in which we think and judge one another and the way in which we see ourselves. Because a challenge to affirmative action, in my view, often represents that someone has some kind of a sense of superiority, and it could be really interesting to me what makes them think they're superior.

HOFF: Mmhmm.

MULLEN: So, in some circumstances, that might be racism. But there's a lot of work by someone named Glenn Singleton, who's done a lot of work in education, Courageous Conversations About Race, and really looking at the inequities in the educational system.

HOFF: Mmhmm.

MULLEN: And we don't often refer to somebody's family's ability to donate thousands or millions of dollars to a school, and then they're, by coincidence, achieving admission someplace as affirmative action—

HOFF: Mmhmm, mmhmm.

MULLEN: —or their unique qualities as a certain musician or something else.

HOFF: Mmhmm.

MULLEN: And so, there are a lot of pathways that help people emerge in a selection process that favor them, and as a result, also discriminate against others.

HOFF: Mmhmm.

MULLEN: And where's the fairness in that, when they're not really reflecting sort of aptitude?

HENDERSON: What Dr Mullen just said reminds me of the role that merit has traditionally played in conversations like this and particularly in conversations around admissions. But I think when we look carefully at what we call merit, what we're really identifying and rewarding is privilege.

HOFF: Mm.

HENDERSON: And I think it's important to be clear about that. I mean, there have been numerous challenges to affirmative action, but there have been few, if any, challenges that I'm aware of to legacy admissions policies. Whether that should be a consideration or

should not be a consideration is certainly debatable. But it seems odd, to put it one way, that practices such as that would be accepted, but practices such as affirmative action would not be acceptable. And if we look at things that have been done to benefit specific disadvantaged groups over time, many if not most of those things have actually been of much broader benefit. And I think the best example I can offer are changes that are the result of the ADA. I think we all benefit from more door handles as opposed to doorknobs. Because even those of us who don't have any particular physical disability, if we have our arms filled with groceries, we can open the door much more easily with a door handle than with a doorknob. And so, in many cases, if we think about things that have been done to support the success of groups that have previously been marginalized and/or discriminated against, most of those changes actually have much broader benefit and also benefit the majority.

HOFF: Mmhmm. Yeah, that's a very important point. Thank you. Many people, including both of you throughout this conversation, have made the point that intelligence and diligence are equally distributed throughout communities, but opportunity might not be. And too often we might focus on the challenges and lack of opportunity facing the advancement of racial, ethnic, gender, or disability diversity and inclusion rather than the many, many successes. So, to end on a higher note, would you please both draw on your experience as clinicians or educators or perhaps even patients to share a success story with our listeners?

MULLEN: Well, I'm feeling optimistic that when I hear a question like that, I'm reminded of the hope that I have that some of the diversity that I'm seeing among our learners and even our junior faculty now is the diversity of thought that is helping create medical school environments where even though underrepresented students and faculty still bear the greatest burden of trying to advance diversity and inclusion, there are broader voices that are supporting them in policy as allies and in calling for change. And that's really important to me because some of the things that I hear sometimes include a reaction to thinking about a success story where in the past, say, when I was in medical school, maybe somebody would've called one of my East Asian colleagues a so-called model minority.

HOFF: Mm, mmhmm.

MULLEN: But now we're all getting to sort of challenge ourselves to say if we're going to think about people that way and say we're trying to be diverse and inclusive, then we're already thinking that somebody else is lesser than.

HOFF: Mm, mmhmm.

MULLEN: And there are more ways of push from the inside in pushing against that kind of thinking now, and I'm very encouraged about that. And maybe it's because—and this is not a commercial announcement—but maybe that's because I work at a medical school that has really been pushing itself to live up to its social, its public social mission.

HOFF: Mmhmm.

MULLEN: And because the students who have decided to come there are holding us to those words.

HOFF: Mm, mmhmm. Great. Thank you.

MULLEN: Mmhmm.

HOFF: Dr Henderson?

HENDERSON: I was just going to say that I think Dr Mullen makes a good point. And I think it's easy to provide sort of anecdotes of one student's success versus another student's success. But I think if we look at things a bit more broadly, if we look at just say, curriculum in medical schools, I mean, social determinants of health, that idea is integrated in medical school curricula across the country. I mean, that idea was I think sort of generated like 100 years ago by folks like Franz Boas, just the whole idea of sort of social epidemiology. But that concept is well integrated into medical education, and it didn't really exist in many ways when I went to medical school. I mean, I think I went to a fairly progressive medical school, and there was incorporation of social issues in some of what we were taught. But it was mostly focused on communication with patients. But I think the recognition that there are systemic issues that greatly impact patients' health and well-being is really important. And I think that is a very, very good example of some of the progress that we are making. There is a very, very, very, very long way to go, but I think there are examples of systems-level changes in medical schools that are potentially useful in combating some of the systems-level inequities that we have across our society. [bluesy funk theme music returns]

HOFF: Drs Mullen and Henderson, thank you so much for your work on this issue of the Journal and for being on the podcast this month.

MULLEN: Thank you.

HENDERSON: Thank you.

HOFF: That's our episode for this month. Thanks to Drs Mullen and Henderson for joining us. Music was by the Blue Dot Sessions. To read our full issue on health justice and diversity in medical school admissions, visit our website, JournalofEthics.org. For all of our latest news and updates, follow us on Twitter and Facebook @JournalOfEthics. And we'll be back next month with an episode on the medical/dental divide. Talk to you then.