3000 by 2000 and Beyond: Next Steps for Promoting Diversity in the Health Professions

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Abstract: In 1991, the Association of American Medical Colleges (AAMC) launched a national campaign to enroll 3,000 underrepresented minority students in medical school by the year 2000. (The AAMC defined underrepresented minorities as blacks, Mexican Americans, mainland Puerto Ricans, and Native Americans, which includes American Indians, Alaska Natives, and Native Hawaiians.*) The initiative, named Project 3000 by 2000, focused on education-pipeline interventions. Although the project did not meet its numeric goal, in large part because of court decisions in several regions of the country that hampered affirmative action programs, Project 3000 by 2000 did have a number of important successes. At a time when there is a need to develop new and creative ways to promote diversity in health professions education, there are a number of lessons to be learned from this project. Large-scale national campaigns serve an extremely useful purpose in promoting diversity in the health professions. And for these campaigns to be successful, it is important that the health professions work together to coordinate their activities and share their resources to ensure that health professions close the diversity gap in the twenty-first century.

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The importance of diversity in the health professions schools is clear. Health professions schools have a societal obligation to select and educate the health workforce of the future. As this occurs, health professions schools must be mindful of protecting and improving the health of the public. There are four practical reasons for promoting diversity in health professions schools.1

First, diversity in health professions education is important in shaping the quality of education for all students. To prepare for the future, the healthcare workforce must be able to understand how different belief systems, cultural biases, ethnic origins, family structures, and other culturally determined factors influence the way in which people experience illness, adhere to medical advice, and respond to treatment. Creating a diverse health professions enrollment allows for this type of learning to occur. Diversity in the classroom also promotes learning skills, such as active thinking, intellectual engagement, and motivation, as well as certain social and civic skills, such as perspective taking, citizenship engagement, and racial and cultural understanding. These are skills that make graduates more “culturally competent.” Culturally competent physicians possess skills and attitudes that help them treat people from a wide range of cultural and ethnic backgrounds.

Second, diversity in health professions education is important for increasing access to health care. We live in a country that is becoming increasingly diverse. Ethnic and racial minority populations of the United States are growing rapidly. During the next two decades, a minority-majority population will emerge, as the white population comes to account for less than a half of the total population.2 This demographic change will have a number of serious implications for our society, one of the most important of which is access to medicine. In a country in which serious racial and ethnic health disparities exist among minority populations—as it does in the United States—health care must very soon begin addressing this serious public health crisis.3 To do this, the health care workforce of the future will have to rely increasingly on minority populations to ensure that all Americans receive adequate health care.

Third, increasing the diversity of the health professions research workforce will lead to an acceleration of advances in medical and public health research. Research agendas are significantly influenced by those who choose careers in investigation. They are also significantly influenced by the backgrounds of those investigators—what they have experienced and observed in their own lives. Creating a more diverse research workforce will lead to broad-

*As of June 26, 2003, the AAMC defines “underrepresented in medicine” as those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population.
ening the medical research agenda and investigations into problems that historically have not received a great deal of attention. These are problems that are often rooted in social, cultural, and behavioral determinants. Examples of these often ignored problems are disparities in access and health status among minority populations. To create this research workforce, however, it is important to begin ensuring that there is a diverse stream of students being admitted into health professions programs.

Fourth, diversity in the health care industry makes good business sense. In a country in which attention is being paid more and more to health care costs, diversity among health care managers is becoming increasingly important to improve business performance. A managerial staff that mirrors the racial and ethnic makeup of a health care organization’s clientele will best anticipate the needs and will best deal with individuals from diverse backgrounds. It is important that the health care industry is supplied with an appropriately diverse health care workforce from which to recruit key leaders and managers.

In addition to these practical reasons, there is a more principled, ethical argument for increasing diversity in health professions education. This argument, that a just society must ensure that equal opportunity exists for those interested in a career in the health professions, can often be more persuasive than the practical reasons for diversity. There are certainly still a great many barriers that exist for many members of racial and ethnic groups. Some of these barriers include less-well-equipped schools serving areas that are home to large numbers of minorities, financial barriers to higher education, and lower levels of academic achievement among parents of minority students. It is also important to remember that racism has not completely disappeared from this country. Even subtle forms of racism still have a great impact on education as teachers often have stereotypic lower expectations for minority students, and minority students often have stereotypic lower expectations for themselves.

### Historical Approach for Achieving Diversity

Before the late 1960s, three-quarters of African-American physicians were trained at the country’s two historically black medical schools, Howard University College of Medicine and Meharry Medical College School of Medicine. The other eighty-one medical schools at that time enrolled, on the average, only one black student every other year. Hispanic and Native American medical students accounted for an even smaller number. Many medical schools had been prohibited, by law, from enrolling black students. Of those that were not, most excluded all but a few minority students because of social, economic, educational, and cultural barriers.

Beginning in the 1960s, serious efforts were made to increase minority enrollment in higher education. Up to this point, health professions schools generally, and medical schools especially, were overwhelmingly white and male. The main mechanism used to increase enrollment for racial and ethnic minorities—and women—was affirmative action. Since that time, affirmative action has proven to be an extremely successful admissions tool for diversifying student bodies.

In 1964, less than 2 percent of medical school matriculants were minorities; in 1971, with less than a decade of affirmative action, more than 8 percent of medical school matriculants were minorities. This truly is a remarkable figure when one realizes that during the same period there were still many flagrantly discriminatory practices occurring in society, and huge barriers still existed for minority students interested in medical school education. The federal government would further encourage minority enrollment by establishing financial aid and other programs for minority and other disadvantaged students.

Though substantial progress was made between the 1960s and 1970s in increasing minority enrollment, by the late 1980s it was clear that affirmative action was not a force that was sufficient on its own to close the diversity gap. To make matters worst, rapid growth in the country’s minority population far outpaced minor increases in minority enrollment so that, by 1990, the degree of minority underrepresentation was worse than it had been in 1975 (see Figure 1). It was for this reason that the AAMC designed Project 3000 by 2000.

### Project 3000 by 2000

The goal of Project 3000 by 2000 was to increase the number of underrepresented minority (URM) students matriculating annually from 1,485 in 1990 to 3,000 by the year 2000. A basic premise of the project was that traditional forms of affirmative action had not been sufficient to achieve diversity goals in the past and that new strategies were
needed to meet the demand for an even more diverse health professions workforce in the years ahead. Two key concepts guided Project 3000 by 2000. First, the project required that medical schools mobilize to create an infrastructure to identify talented young minority students who were interested in becoming physicians. Project 3000 by 2000 envisioned an education pipeline that began at the beginning of high school and ended at the end of medical school. At the beginning of this pipeline, a student’s interest and ability to enter an education in medicine could be enhanced or dissipated. This leads to the second key concept—that academic intervention, to meet its goal, must not be piecemeal. To enhance a student’s ability and desire to become a physician, Project 3000 by 2000 envisioned broad-based interventions that would influence the day-to-day experiences of students in their classrooms.

Medical schools involved in the project appointed a faculty member or administrator to coordinate Project 3000 by 2000 on their campuses. In setting up a program, these schools were expected to:

- Conduct a strategic assessment to examine the medical school’s past and current activities, as well as future potential of minority enrollment;
- Identify high schools with high minority enrollment to serve as magnet health professions high schools. Students in these schools were to be targeted with academic enrichment opportunities;
- Forge partnerships and agreements with high school and college partners to make sure that early parts of the pipeline facilitate progression to latter stages, reducing barriers that could impede progression;
- Reassess medical school recruitment, admissions, financial aid, and academic support programs, which are all connected to the pipeline system; and
- Ensure that the social environment of the medical school is hospitable to students from diverse racial and ethnic backgrounds.

To promote this agenda, the AAMC sponsored many programs and activities. A technical assistance manual was distributed to medical schools, as well as custom data report supplements for each medical school. The AAMC was also influential in establishing funding for individual medical school partnership programs by coordinating with foundation funding sources.

Project 3000 by 2000 had a number of successful elements. The program created a public education campaign for medical school recruitment, retention, and academic achievement. By engaging medical school deans in these issues, the program was able to galvanize the medical education com-

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**Figure 1. Percentage of underrepresented minorities among medical school matriculants and in the U.S. population, 1950-2001**


**Note:** For this comparison, “underrepresented minorities” are African Americans, Mexican Americans, Native Americans, and mainland Puerto Ricans.
community around this vital national initiative. The program was able to bring together significant foundation funding sources over a large period of time. It was able to create unlikely, unusual, and uncharacteristic partnerships among K-12 school systems, colleges, health professions schools, and community-based organizations. This contributed to the growth of the pipeline model as a way to address the academic needs of students as they progress from precollege years into baccalaureate and postgraduate health professions schools. A significant body of published work analyzing many of the difficult issues related to minority academic achievement was produced in relation to Project 3000 by 2000, serving as a resource to guide future programs and initiatives. Finally, Project 3000 by 2000 was able to reverse the negative enrollment trends that emerged from 1975 to 1990. The number of minority matriculants to U.S. medical schools increased 36.3 percent between 1990 and 1994 or to 12.4 percent of the total number of medical school matriculants.3

Though Project 3000 by 2000 technically ended in 2000, two major programs continue today. These programs are the Health Professions Partnership Initiative (HPPI) and the Minority Medical Education Program (MMEP). Funded by the Robert Wood Johnson Foundation and the W. K. Kellogg Foundation, HPPI provides funding to medical and other health professions schools. Through HPPI, schools collaborate with local K-12 schools and undergraduate colleges as partner institutions to improve curricula and provide new learning opportunities, thereby boosting the academic performance of underrepresented students. MMEP is a six-week residency summer enrichment program offering college students intensive medical school preparation. Funded by the Robert Wood Johnson Foundation, this national program is offered at eleven medical school sites around the country to address underrepresentation in medicine.

New Realities

There is a stark reality facing health professions schools today. At the same time that racial and ethnic minority populations are rapidly becoming larger and far more influential, legal challenges to affirmative action continue unabated. Despite the June 23, 2003, U.S. Supreme Court decision in Grutter v. Bollinger et al., in which the compelling state interest of promoting diversity was upheld, as was the use of affirmative action as a mechanism for promoting diversity, anti-affirmative action efforts are being organized in a number of states. A ballot initiative in Michigan may ban the use of affirmative action in public schools, as have ballot initiatives in California and Washington State. Those ballot measures that were organized and approved in those states in the mid-1990s resulted in dramatic declines in underrepresented minority enrollment in many health professions schools and contributed to the failure of Project 3000 by 2000 to reach its numeric goal.6

It is clear that much more needs to be done to increase underrepresented minority enrollment in health professions schools. Profound disparities in the quality of primary schools, and especially the differences between urban and suburban public schools, are extreme, and contribute to promoting further disparities in the makeup of the classes of institutions of higher education. However, despite these obvious problems and despite the clear benefits of diversity, there is still a need to make a persuasive case for diversity in health professions education. Not only do the public, courts, and policymakers need to be convinced of the need to have diversity, deans also must be convinced to make diversity a top priority for their health professions schools.

One of the important lessons from Project 3000 by 2000 was that affirmative action on its own will not be enough to close the diversity gap in medical schools. Though affirmative action is an important mechanism for promoting diversity, to truly and adequately address the problem of minority underrepresentation, health professions schools must employ a broad spectrum of pragmatic and varied programs, each addressing a particular problem, and collectively promoting diversity on our nation’s college campuses.

Next Steps

Project 3000 by 2000 demonstrated that partnerships between high schools and health professions schools, though challenging and difficult to establish and nurture, can be established.8 A decade ago, it was unknown whether these unlikely, unusual, and uncharacteristic partnerships could succeed. Today it is known that they can be established, and can be successful if they are cognizant of the needs, realities, and cultures of significantly different institutions.9 It is important that the health professions work together to ensure that diversity continues and is in-
creased in the health professions schools. It is for this reason that a national campaign similar to Project 3000 by 2000, coordinated by all schools of the health professions, is very much needed.

Pipeline interventions at the high school level, and even at the pre-high school level, are still needed. This is where the most severe disparities exist today in American education, and the source of many of the disparities in academic achievement between minority and non-minority students. Interventions in low-performing high schools that have large numbers of underprivileged or underrepresented minority students may succeed in producing a diverse group of students that is both motivated and capable of succeeding in health professions schools. This will be the central objective of a new national campaign.

An important element of Project 3000 by 2000 was its education campaign targeting the medical education community. This education campaign was important in making the case for diversity to medical school deans and administrators, and it resulted in high levels of participation by medical schools in the project. Today an education campaign is still needed for the health professions education community, but it is also needed for the public at large. Members of the public must not only understand why diversity is so vitally important for the health of the nation; they must also believe this themselves. It is in this way that we can ensure that our activities in the future will not befall the same fate as affirmative action, and come to be viewed by some as ineffective and unnecessary.

This type of national campaign is ambitious, and it would be advantageous to identify partners to assist the health professions schools in this endeavor. Luckily, there are a number of candidates. One potential partner is the health care industry. As the direct recipient of health professions schools graduates, the health care industry has a great deal of interest in ensuring that the health care workforce of the future is diverse. More and more, a diverse health care workforce is necessary for delivering high-quality care efficiently to the ever-more diverse population. The health care industry could bring vast resources to a national campaign, as well as long-term stability to a pipeline program.

As diversity in the health profession schools will have a direct impact on the health of the public, additional partners could be established among offices and agencies of the federal government, state governments, and municipal governments. These government entities could bring a great deal of knowledge and authority to a pipeline program. Similarly, partnerships could be established with philanthropic foundations interested in education or public health.

As it stands today, there is some doubt as to how diversity will be achieved in the health professions schools in the future. A large-scale national campaign, coordinated by all the health professions, is a good first step to begin addressing the health professions diversity gap in the twenty-first century. Working together, the health professions could coordinate the efforts not only of their own institutions, but also the efforts of the health care industry, government, and philanthropic organizations to improve pre-health professions education in low-performing high schools. This could result in leveling the playing field in academic achievement between minority and nonminority students who are interested in entering a health profession education. Clearly this is not the only answer to addressing the diversity gap, and this national campaign could be viewed as being far too ambitious and unrealistic. But to ensure that there is proper diversity in the schools of the health professions, it will be necessary to think creatively and think big.

REFERENCES