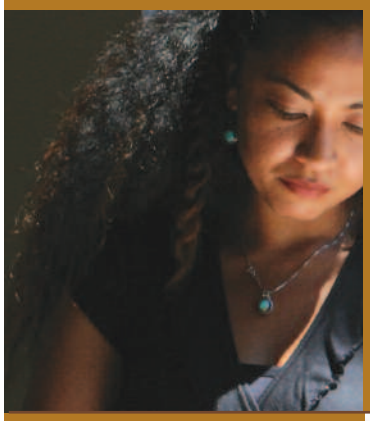
representing the new majority



SPRING 2008

PART III: A STATUS REPORT ON THE DIVERSITY OF THE UNIVERSITY OF CALIFORNIA MEDICAL STUDENT BODY

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THE GREENLINING INSTITUTE

ACKNOWLEDGEMENTS

In the fall of 2004 The Greenlining Institute published the first in our three-part series of reports that examined the diversity at the University of California medical schools. The first report focused on the medical school career staff, the second focused on the faculty and this third part examines the diversity of the student body. These reports are part of a body of work that we hope will contribute to the discourse on the larger issue impacted by diversity, namely, the quality of care for California's increasingly diverse population.

The Greenlining Institute would like to acknowledge the foundations, organizations and leaders that helped make this effort a reality:

The California Endowment for their support of Greenlining's efforts on health workforce diversity. Their generous support allowed us to invest time and resources towards this project.

The California Wellness Foundation for their commitment to supporting the members of our Leadership Academy whose labor, talent and intellectual prowess was instrumental in completion of every one of these reports.

The Association of American Medical Colleges, Gwen Garrison in particular, for providing us with the data on student body diversity at the University of California medical schools.

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All of our Leadership Academy Fellows who dedicated numerous hours in research, data gathering & analysis and in writing multiple drafts of these reports; Tiffany Green (who authored the first report on diversity of the career staff at UC), Abu Kanu and Angela Echiverri (who authored the second report on the diversity of the faculty and who raised the standard for writing amongst our Academy participants), Kellie Middleton (who secured the student data for us and conducted the qualitative interviews that are used as anecdotal content in the report on diversity of the student body). Hilary Joy also contributed to the second report.

The author of this report, christian gonzález-rivera, who has proven an invaluable primary contributor to this report and whose talent for synthesizing data proved that great things can be accomplished during challenging times.

John Yuasa, whose early efforts and leadership set the foundation for future reports.

Molly Hart, whose leadership and management skills contributed to early reports.

The Greenlining Institute's co-founders, John Gamboa and Robert Gnaizda, who will be retiring at the end of 2008.

Thank you all.

Hector Javier Preciado
Health Policy Director
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PREFACE

Making the Case for a Diverse Health Workforce

There is a strong and crucial case to be made for increasing diversity in the health workforce, and it is amply supported by research literature. The case rests on three basic pillars:

- The need for increased linguistic and cultural competence in an increasingly diverse state
- The proportionally greater need for health services among the state's minority populations
- Minority health practitioners' strong record of practicing in medically underserved areas and serving underserved populations.

Linguistic and Cultural Competence

California is by far the most diverse state in the nation, with Latinos and Asian Americans leading the way in diversifying the state. Latinos are the fastest growing segment of the population, increasing their numbers by 15.4% since the year 2001. Asian American Californians, who increased their numbers by 7.5% in the same period, are the second fastest-growing population in the state, and African Americans increased their numbers by 7.51%. In contrast, the numbers of White Californians has increased by only 0.6% in the same period.[1]

Currently, 49.3% of Latino and 30.1% of Asian American Californians speak little or no English, which presents a formidable challenge to their ability to access quality health services.[2] Kevin Grumbach, et al. published a report this year based on the data from the California Medical Board Survey that found that only 18.1% of California physicians speak Spanish, 4.3% speak Mandarin, 2.2% speak Cantonese, and 2.0% speak Vietnamese.[3] Clearly, there are insufficient linguistically competent physicians in California's physician workforce.

In addition, Grumbach et al. found that while the majority of Spanish-speaking physicians are non-Hispanic White due to the overwhelmingly larger number of White physicians in the state, only a minority speak a non-English language. In contrast, almost all Latino physicians speak Spanish, and they comprise 30% of all Spanish-speaking physicians in the state, despite comprising only 5% of all California physicians. The importance of that five percent of Latino physicians is critical to California's rapidly growing Latino population.

For Asian/Pacific Islander languages, 97.4% of East Asian language speakers are Asian American. Looking deeper into the data provided by the California Medical Board Survey, we find that 59.3% of Asian-language speaking physicians speak an East Asian language, while only 16.8% speak Southeast Asian languages like Hmong, Cambodian, and Lao, and only 14.8% speak Tagalog.[4]

Census data does not disaggregate the population tallies for Asian Americans, making it difficult to determine whether there are insufficient Southeast Asian and Filipino speakers to adequately serve those populations around the state.

The language barrier for Latino and Asian American Californians over age 60 is particularly great. Six out of ten Latinos 60 years of age or older speak little or no English, as do half of older Asian Americans.[5] While there are more English speakers among adults ages 50-60 than the more elderly, rates of English proficiency remain lower than for younger populations. This is of especially great concern since the elderly are the fastest growing age group in California, growing at twice the rate of the general population. The elderly are also the age demographic most likely to depend on access to quality health services.[6] While this increase in the elderly population will occur throughout the state, the greatest increases from now until 2020 are expected in one of the regions with the least access to health services (and one of the greatest concentrations of Latinos), the Central Valley.[7]

Studies have shown that patient satisfaction increases significantly if the patient and the doctor are of the same race. These findings are evidence of the importance of the "soft skills" of effective communication, empathy, patience, and cultural sensitivity to the work of a doctor. Such skills, though crucial to the success of what most patients would consider to be a "good doctor," are much more difficult to measure than academic achievement. However, these studies on the relationship between culture and communication show that the patient-doctor relationship is much stronger when both are of the same race.[8]

Cultural competency and respect for diversity are not innate, they are learned. The work of a doctor in California will increasingly require communication and interaction with people of diverse backgrounds. The training ground for acquiring the soft skills for being an effective practitioner in a diverse society begins not in the clinic, but in the state's medical schools and universities, or earlier. Increased diversity in the faculty and student body of UC medical schools would provide the level of interaction with diversity necessary to create a culturally competent health workforce.

As Part II of Greenlining's three-part series on diversity in the UC medical school system shows, the diversity of the faculty fails to reach parity with the diversity of the state.[9] As this report shows, the diversity of the student body also fails to reach ideal diversity, with serious repercussions for diversity awareness and cultural competency among California's medical school graduates.

A recent Los Angeles Times article[10] reported on Clinica Romero, a clinic in East Los Angeles that serves primarily Mayan immigrants, who are usually unfamiliar with Western medical practices due to never having access to hospitals and clinics in their home countries. The article profiles the efforts of clinician Idalia Xuncax, herself Maya, in reaching out to the area's Mayan residents.

"Without a diverse class, individuals can continue living with no awareness of cultural differences, no understanding of language barriers or health disparities. And those individuals may one day be taking care of my people."

–First Year African American Student, UCLA

"How can you effectively communicate with a patient if you do not understand their background and cannot put yourself in their shoes?"

–Student, UC Davis

Her outreach and her credibility in the community has brought to light serious health disparities among Mayan immigrants, and has certainly improved health outcomes for the hundreds of people the clinic has served. Given the particular cultural isolation of Mayans living in Los Angeles, it is unlikely that anyone not from the community could wield sufficient credibility to provide healthcare to this community.

Minorities are Disproportionately Affected by Poor Health

Minorities are disproportionately affected by poor health due to a lack of access to quality healthcare. Indeed, while over 75% of Whites have health insurance, only about 60% of Asians, 57% of African Americans, and less than 50% of Latinos do. This especially is of concern for African American and Latino children, who fail to receive the basic, preventive medical care that is crucial for lifelong health. While nearly 70% of White and Asian children are up-to-date on their vaccinations, only 50% of Latino and 45% of African American children are.[11]

African Americans are particularly affected by chronic illnesses at rates higher than for all other races, signaling a need for both increased levels of preventive care in the African American community, as well as more research into the causes of illness in this community. For example, African American mothers are twice as likely as any other racial/ethnic group to have children with low birth weight. This rate has not changed since the 1970s. African American babies are also twice as likely as those of any other racial/ethnic group to die before the age of 1.[12]

In addition, African Americans are twice as likely as any other racial/ethnic group to be living with HIV/AIDS, and those between the ages of 25 and 34 are more than twice as likely than Whites of the same age range to die from it. African Americans between the ages of 25 and 34 are almost three times as likely to die from homicide[13] due to the structural inequality that places most poor African Americans in concentrations of poverty.

Clearly, advances in medicine have not benefited all Americans equally. This is especially true with the issue of low birth weight and high infant mortality in African American newborns. If the figure for the rate of infant mortality among African Americans in California were to be placed in a global context, it would be in 93rd place among 221 nations, on par with Jamaica and Panama.[14] This means that nearly 42% of the world's nations have a lower infant mortality rate than African American Californians. In contrast, 19% of the world's nations have lower infant mortality rates than the United States as a whole.

The problem of poor access to quality healthcare by lower-income minorities is an issue that affects all Californians, since the illnesses and the negative health indicators that affect one portion of our population are likely to affect the state as a whole. Lack of access to preventive care translates to higher social and economic costs of providing health care.

Minorities are Much More Likely to Serve the Underserved

It has been demonstrated by various studies that physicians of color tend to work in communities that are mostly comprised of people of color. In addition to being more likely to care for poor patients, African American physicians are also more likely to care for Medicaid patients and Latino physicians are more likely to care for uninsured patients. Minority physicians are much more likely to practice in areas experiencing physician shortage, than are non-minority physicians.[15]

Federally-designated Health Professional Shortage Areas (HPSA) are predominantly found in rural and inner-city areas of concentrated poverty, particularly African American and Latino impoverished neighborhoods.[16] These are areas where there are insufficient doctors to meet the health care needs of the resident populations. Medical facilities in these areas are generally overcrowded, or patients must travel long distances to receive primary medical care.

Grumbach, et al. found that while only 9% of physicians practicing in the state are URM, about 18% of URM physicians practice in HPSA, compared to only 11% of White physicians and 14% of minority non-URM (mostly Asian American) physicians. The report shows that greater percentages of URM physicians also work in metropolitan areas with higher African American and Latino populations, as well as in metropolitan areas with a larger percentage of poor people. In addition, almost a quarter of URM physicians work in federally-designated Medically Underserved Areas (MUA), while only 15% of Whites and 19% of non-URM minorities do.[17]

Diversity is also important for achieving equity in medical research. Research agendas at universities and other institutions are informed and influenced by researchers' personal interests, and often those are informed, in turn, by the particular researchers' backgrounds. Minorities are more likely to have a personal interest in, and be aware of, health issues that affect their communities that deserve a place in the health research agendas.

Accordingly, a diverse student body is more likely to discuss and act upon grave inequalities in health outcomes among underrepresented minorities. In fact, surveys of matriculating medical students have shown that 51% of African American, 33% of Latino, and 41% of Native American entering students indicated that they are very likely to use their medical knowledge to serve underserved communities, compared to 18.4% of Whites.[18]

"These students are going to serve my people in two years. If they do not understand cultural differences now, and continue to remain in isolation, it is going to be worse when they take care of patients."

–Second Year Latina Student, UC Davis

Making the Case and Creating Change

As the primary physician-producing public institution in the state, the University of California medical schools have an obligation to ensure that the students they graduate each year are fully prepared to serve Californians of all races and socioeconomic levels. Preparing doctors to work with diverse patients means educating them to be fully aware of the challenges presented by cultural and linguistic barriers and the compound effects of poverty and disparity on health.

Effecting change in California's physician workforce means visualizing the health professions educational pipeline and taking steps to address diversity issues at each step. Students of color at UC medical schools, especially those from disadvantaged backgrounds, should be given proper support to ensure that they graduate. Minority college students should be encouraged to pursue a premedical track, and receive support from course completion through medical school applications. Enrichment programs at the high school level, both general and medical education-focused, should work to keep URM in school.

A proper commitment to ensuring diversity among our state leaders means taking responsibility for disparities in the quality of primary and secondary education that different populations receive, and ensuring that all students truly have equal opportunity for success.

Larger issues of educational equity aside, the University of California has within its jurisdiction ample capacity to support the enrichment programs and post-baccalaureate programs that will create a larger applicant pool, and the ability to adjust its admissions criteria to include measures that would evaluate a potential student's ability to address the most pressing health issues in our state today. If such admissions criteria were in place, and executed by diverse admissions committees, we would witness an increase in medical school student diversity. If the University committed to expanding current joint programs and creating new ones, thereby increasing the number of seats at medical schools over a wider geographic range, we would also see greater representation by URM.

EXECUTIVE SUMMARY

This report is the third installment of the *Representing the New Majority* series, which examines the racial and ethnic diversity of the five-campus University of California medical school system using data on the number of applicants, acceptees, and matriculants of each race from 2001 to 2007.

The purpose of this study is to examine how effectively the UC medical schools are recruiting, retaining, and preparing a physician workforce that represents the diverse populations of California. As a premier public institution, the UC has the responsibility of producing future health care professionals that meet the needs of all Californians. Without a diverse and culturally competent healthcare workforce, access to quality health care will continue to decrease for all, but especially for those who need it the most.

Unlike the previous two reports[19,20], this report includes the voices of medical students who comprise the future health workforce. Throughout the report, research findings are supplemented by the insights of current UC medical students, who show genuine concern for the lack of diversity in the medical student body.

"How can we take care of the health care needs of our communities when we are not even close to representing the demographics of the state?"

–Third Year Latino Student, UC Irvine

Key Findings

With a population that is already minority-majority and with health care reform high on the agenda of both the state and federal government, opportunities are ripe for getting the issue of diversity in the healthcare workforce on the tables of discussion and policy action in California and across the United States.

This report intends to continue discussions on the topic of diversity in the state's healthcare workforce currently underway by offering a snapshot of diversity trends at California's primary producers of physicians during a time of major demographic shifts in California. Our analysis shows that there are insufficient numbers of under-represented minorities (African Americans, Latinos, and Native Americans) graduating from the eight medical education programs in the University of California's five medical school campuses. This report shows, among other findings, that:

1. Underrepresented minorities (URM) comprise 44% of California's population[21], **but only 17.8% of first-year medical students (2007 entering class) across all eight programs; a 38.2% representation gap.**

2. Latinos have the largest representation gap of all URM, comprising 35.9% of the population of California[22] and 62.7% of state population growth between 2001 and 2007[23], yet comprising **only 9.3% of first-year UC medical school students.**

"I believe that…more medical schools should place a greater emphasis on cultural diversity."

–First Year Filipino Student, UCSF

3. Latinos have experienced a **60% increase** in their numbers at UC medical schools, the greatest growth among all minorities in number of medical school students between 2001 and 2007.[24] **Yet these gains fail to keep up with their increase in California's population.**

4. The disparity between the representation of URM in California's population and in the UC medical student body grew from 2001 to 2007, since **the proportion of URM in California's population is growing at twice the rate of the proportion of URM in the UC medical student body.**

5. Numbers of African Americans and Native Americans among medical school matriculants have remained stagnant over the seven-year study period (at around 4.2% and 0.4%, respectively), while the **numbers of both in California's population have been increasing** (by 7.5% and 15.8% since 2001, respectively).[25]

6. URM are matriculating in UC medical schools at about the same rate at which they are applying, meaning that more must be done to increase the number of URM that apply.

7. The rescinding of SP-1 by the UC Regents in 2001 had a positive effect on minority enrollment at UC medical schools, and this effect is a useful foreshadowing of the effect that repealing California Proposition 209 may have on minority enrollment.

The current disparity between minority representation in the UC medical student body and in California's population is so severe, that even if all the UC medical schools were to matriculate *only* minority applicants starting next year, **it would take them 38 years to graduate enough doctors to achieve parity with the current racial makeup of California.**[26] By then, according to population projections, the state's nonwhite populations would have expanded further.

Methods and Sources

The data analyzed in this report, sourced from the Association of American Medical Colleges (AAMC), is disaggregated to show the number of applicants, acceptees, and matriculants to each of the eight medical school programs, which are comprised of the five medical school campuses: UC Davis (UCD), UC Irvine (UCI), UC San Diego (UCSD), UC San Francisco (UCSF), and UC Los Angeles (UCLA-Geffen), as well as the three joint programs: UC Berkeley/UCSF Joint Program (UCB/SF Joint), UCLA/Charles R. Drew University of Medicine and Science (UCLA Drew), and the UC Riverside/UCLA program (UCR/UCLA).

The data from the AAMC that we analyzed was presented for each of the following racial/ethnic groups: Asian, Black, Hispanic/Latino, Native American, Other, and White. In addition, there were total figures for Minorities, a category which includes Asian, Black, Hispanic/Latino, and Native American. For the purposes of this report, we created an additional category of Underrepresented Minority (URM), which includes Black, Hispanic/Latino, and Native American. Throughout this study, members of the "Black" category will be referred to as "African American" and those of the "Asian" category will be referred to as "Asian American."

Also in this report, "applicants" refers to prospective students who applied to each medical school program. The sum of all applicants does not represent a population of discrete individuals, as the data does not distinguish among individual applicants who may have submitted an application to more than one school.

"Acceptees" refers to applicants who were accepted for admission into each medical school program. Again, acceptees may have been accepted to more than one medical program.

"Matriculants" are the acceptees who enrolled in a particular medical school program. This population is, of course, composed of discrete individuals, and so this population is the best indicator of overall medical school diversity, and the one used throughout this report.

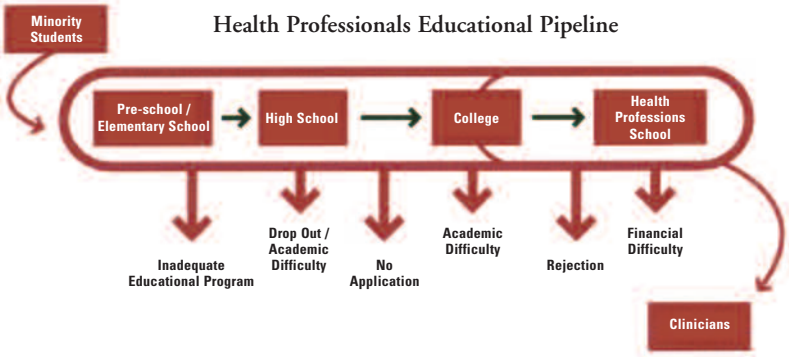
The other component of the report is the student narratives, which are woven into the quantitative findings in this report. Kellie Middleton, Health Policy Fellow at the Greenlining Institute visited four of the five University of California medical school campuses: UC Davis, UC San Francisco, UC Los Angeles, and UC Irvine, and asked volunteers from among the first and/or second year students, both minority and non-minority, to engage in a brief face-to-face interview. On average, each interview took 10 minutes to administer.

We thank all the students who participated in the study and contributed to this final report. At all four campuses, the students were very willing to work with us in an effort to increase diversity and improve dialogue among students of different racial, ethnic backgrounds for the betterment of their respective universities.

INTRODUCTION

African Americans, Latinos, and Native Americans comprise 56% of California's population, yet only 9% of all practicing physicians in the state.[27] This incredible disparity contributes greatly to the pronounced gap between the quality of medical services available to these populations and that which is available to select White and Asian American populations.

This report begins by analyzing diversity trends in the medical schools of the University of California, because as public schools funded by California taxpayers—*all* California taxpayers—they are charged with the obligation to ensure that their operation benefits and improves the lives of all Californians. There is a growing consensus among health education professionals and scholars that diversity—in terms of students, faculty, and academic treatment of health disparities among races—is an integral and inseparable component of a complete medical education, and that physicians not trained in cultural competency, intercultural communication, and racial/ethnic differences in health outcomes cannot fully serve an increasingly diverse population.



Health Professions Educational Pipeline

We place these findings in the context of the health professions educational pipeline, which sees the road to the M.D. as beginning not at medical school, but much sooner: in elementary school. The diagram above[28] clearly and dramatically shows the pipeline that turns students into clinicians, as well as all the challenges and pitfalls (the "leaks" in the pipeline) that exist along the way.

The diagram makes clear that there are leaks at every junction in that pipeline. Unfortunately those students who are most likely to "leak out" of the health professions educational pipeline are our state's large and growing African American and Latino populations. Data on educational achievement from the US Census shows that:

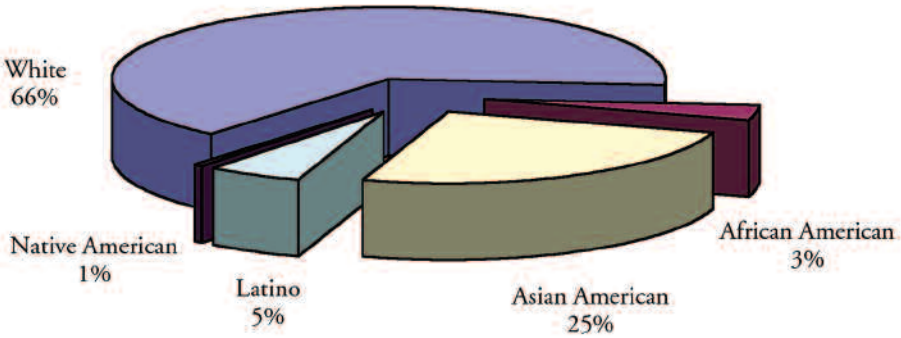
- African Americans are 8 times more likely and Latinos 10 times more likely than Whites to live in an area of concentrated poverty with low-achieving elementary schools.[29]
- Latinos and African Americans in California are 84% more likely than Whites and 271% more likely than Asian Americans to drop out of high school.[30]
- African Americans in California are 42% more likely and Latinos 30% more likely than Whites to drop out of college.[31]

All of these challenges have created a situation where insufficient numbers of underrepresented minorities have the adequate preparation to enter medical school, and as a result, the demographics of the state's health workforce are vastly different from the demographics of the state. Whites and Asian Americans are adequately represented, while African American, Latino, and Native American physicians are in short supply. The disparity in the representation of Latinos in the state's pool of physicians is particularly severe: while Latinos comprise 37% of California's population, they comprise a mere 5% of practicing physicians.[32]

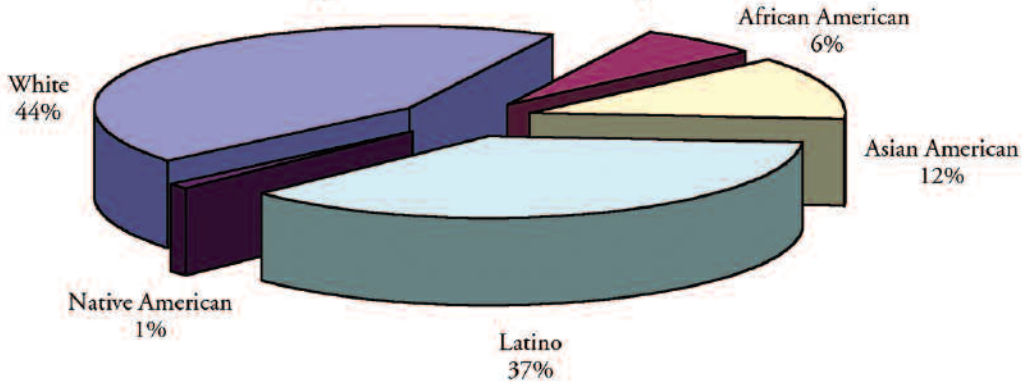
When analyzing the diversity of current medical school classes at the University of California, we must take into account two determinants: the effect of the existence (or lack) of active diversity recruitment at the medical schools and the possible pool of underrepresented minority students who have sufficient preparation to apply to medical school. The first question speaks to efforts at the medical schools themselves to diversify their student bodies within the constraints of California Proposition 209, while the second question refers to the much larger issue of the severe lack of education equity that underrepresented minorities experience in California and across the United States.

However, this report will focus on diversity trends at the UC medical schools from 2001 to 2007, and will offer some recommendations pertaining to strategies for improving diversity in medical education.

Racial and Ethnic Representation in California's Physician Pool



Racial and Ethnic Representation in California's Population



We have a diverse class, but if we are not taking advantage of the different backgrounds and perspectives present, then what's the point?"

–First Year Non-Minority Student, UCSF

UC Once Led the Nation in Medical School Diversity

From 1978 to the early 1990s the University of California participated in the Association of American Medical College's affirmative action-oriented effort to increase diversity in medical schools across the United States. Aiming to increase enrollment of minorities to 3000 students by the year 2000 (there were less than 1,500 by 1990), the program was called Project 3000 by 2000.[33] California, with its high percentage of underrepresented minorities in the population, had a clear advantage, and the numbers of URM enrollees at the state's public medical schools were among the highest in the nation.

The results of these efforts began to taper off by 1993-1994, when URM matriculation in UC medical schools began to decline. The numbers of URM among applicants, acceptees, and matriculants declined steadily through the adoption of Standing Policy 1 (SP-1) by the University of California Board of Regents and of Proposition 209 by the State Legislature. It was not until the numbers of URM in UC medical schools had plummeted to almost half their peak levels, that the University of California took decisive action to change the pattern.

In 1999, then-UC President Richard Atkinson appointed the Medical Student Diversity Task Force to review diversity trends among applicants, acceptees and matriculants to UC medical schools, and to produce recommendations for increasing diversity at the schools and preparing more URM for health careers.

The Task Force produced the report[34] the following year, and their recommendations recognized the need for pipeline and pre-baccalaureate programs to prepare more URM to enter medical school, the need for UC medical schools to conduct outreach to and recruit students from underserved communities, the need to expand support to URM students already enrolled in medical school, and to ensure diversity in medical school admissions committees.

Finally, in 2001 the University Regents decided to rescind SP-1, and the result was a marked increase in URM enrollment. This report, in analyzing UC medical school diversity data from 2001-2007 will discuss the trends in minority enrollment that occurred after the University of California reaffirmed its commitment to diversity by rescinding this damaging policy. In effect, it will continue the Task Force's ground-breaking work that spurred the Regents into taking action on medical student diversity in the wake of Proposition 209, echo some of their recommendations, and provide some new recommendations for further work.

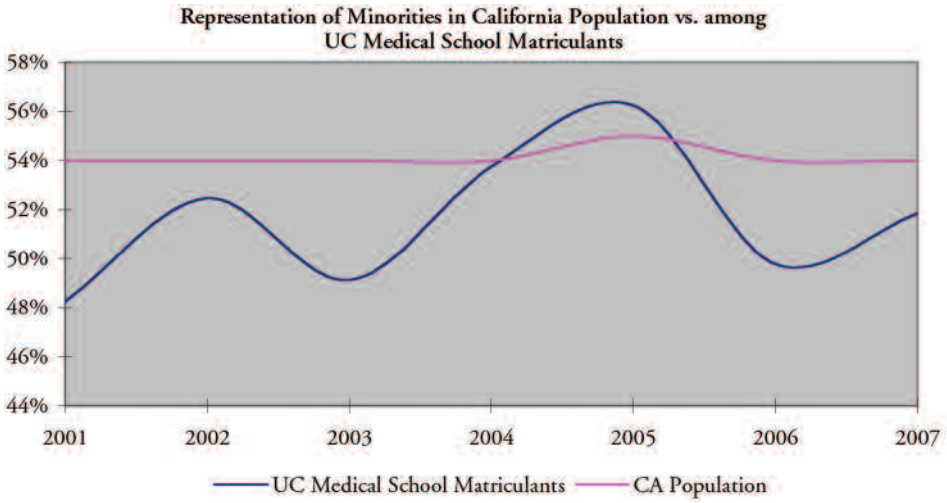
KEY FINDINGS

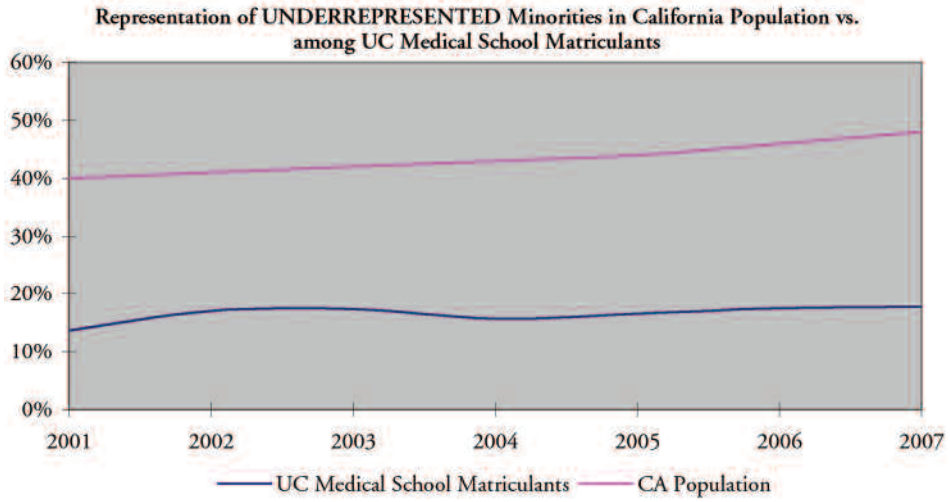
FINDING 1: The University of California is failing to train enough physicians of color to meet the present and future health needs of an increasingly diverse state. The disparity between minority representation in California's population and in the UC medical student body is growing.

Minority representation in the UC medical school system has not achieved parity with the makeup of California's population, nor has it kept pace with the shifting demographics of the state. As the population of people of color in the state continues to grow, the pool of medical students of color has remained stagnant, decreasing the possibility that Latino, African American, and Native American patients may receive quality and culturally competent health service.

Out of 4,084 matriculants in UC med schools over the past 7 years, less than 200 were African American, a little over 500 were Latino, and only 11 were Native American. In the meantime, California added 153,800 new African Americans and 1,739,748 new Latinos to its population during those same years.[35] That means that the UC system matriculated one African American student for every 777 African Americans added to the population, and one Latino student for every 3,276 Latinos added.[36] In contrast, the UC system added one Asian American medical student per 457 added to the population. *The growth in the supply of minority doctors is not keeping up with the growth in the underrepresented minority population.*

The graphs on the following pages compare the trend in the population of each race from 2001 to 2007 to the trend in minority matriculation at all UC medical schools combined.



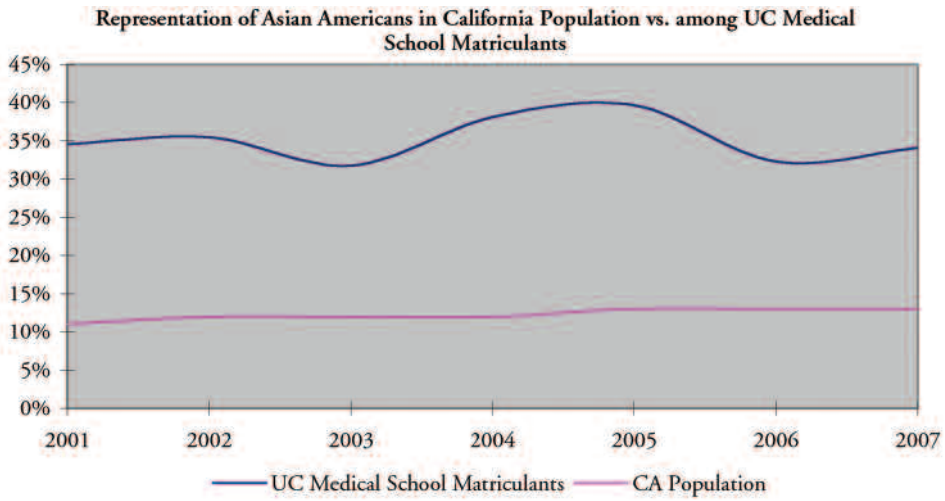


Asian Americans

White and Asian American matriculants are represented at rates higher than their representation in the state's population, while Latino and African American student representation is severely lacking.

However, the data for Asian Americans hides the heterogeneity of the various ethnicities contained within the term. There are vast differences in representation, health outcomes, and educational achievement among East Asian, South Asian, and Southeast Asian groups, all of which are obscured by insufficiently disaggregated data.

The AAMC should disaggregate future data on Asian Americans to tabulate figures for individual nationalities, and future research should look into the inequalities that will indubitably be revealed.

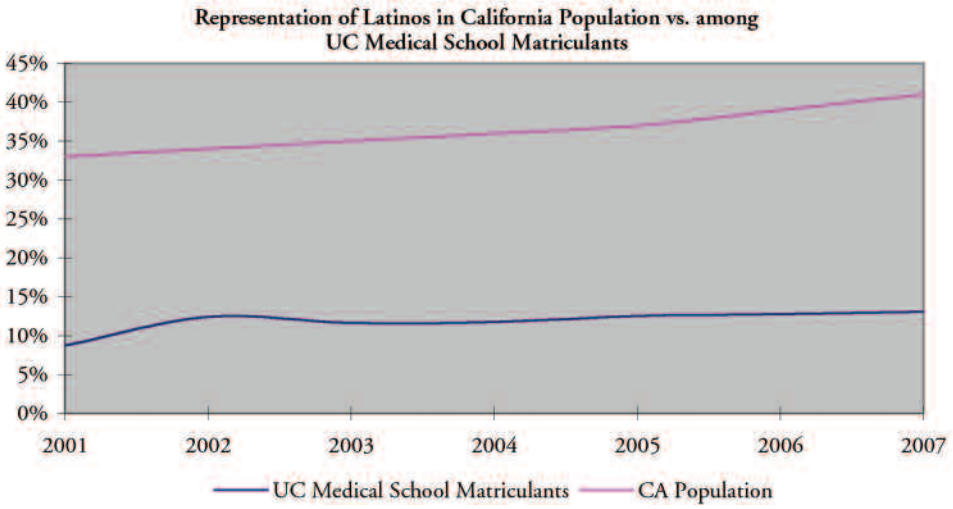


Latinos

The lack of representation among Latino medical school matriculants is the widest of all racial/ethnic groups in the state; while Latinos comprise 35.9% of California's population, they represented only about 14% of all matriculants to the class of 2007.

Fortunately, the proportion of Latinos among medical school matriculants has been increasing each year, yet these increases are failing to keep up with the rate of growth of the Latino population in California. Latinos are by far the fastest growing segment of the population, increasing their numbers by 19% since the year 2000.

Although there are now 60% more Latinos represented among matriculants to UC medical schools than in 2001, there are still fewer than 100 Latino doctors being produced each year. The UC medical schools need to dramatically increase their enrollment in order to change these figures, or else fail to adequately serve the health needs of a population that will be majority Latino by 2050.

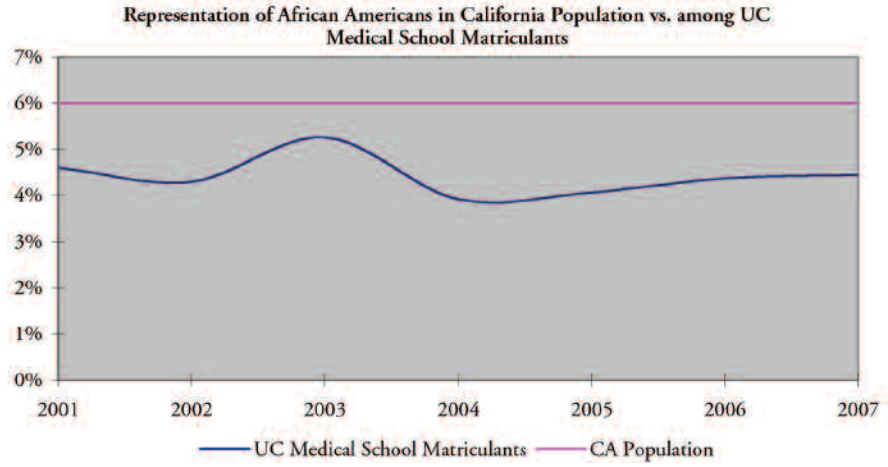


"You cannot be fully educated unless you interact with people different from you."

–Second Year African American Student, UC Davis

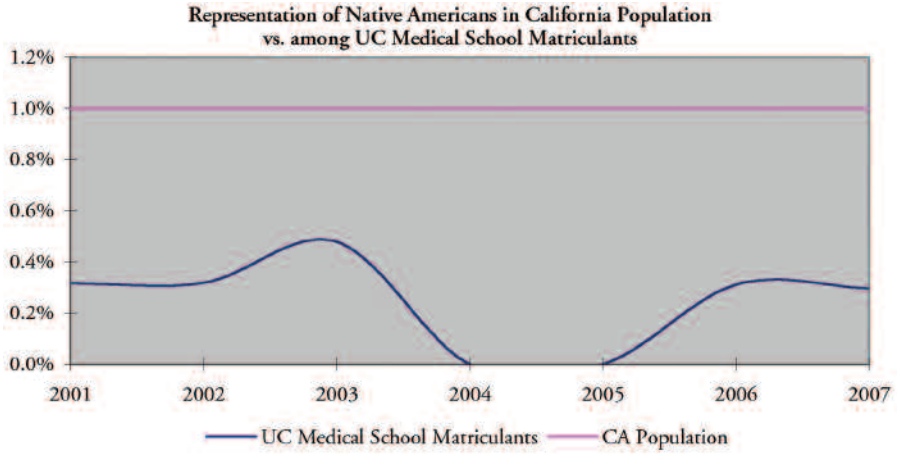
African Americans

African American representation among medical school matriculants has remained mostly flat over the past seven years, even though their numbers in the state's population have increased by 7.5%. This widening gap in representation parity, although smaller than that seen among Latinos, is especially serious given poor African Americans' lack of access to healthcare, and to the many health factors that disproportionately affect these communities. Surveys of African American medical school matriculants have shown that fully 51% of them—more than any other ethnic group—indicate a desire to use their medical knowledge to serve underserved communities. Therefore, there is a very clear nexus between the problem of lack of access to healthcare in poor African American communities in California and their lack of representation among UC medical school matriculants.



Native Americans

Only 11 Native Americans matriculated in UC medical schools over the past seven years, and the rate of Native American matriculation has not increased, hovering at an average of 0.4% over the time period. Although Native Americans have the smallest nominal representation gap between their proportions in UC medical school matriculants and in California's population, this gap has serious repercussions for the health of Native American communities in the state due to the high level of cultural competence required to be an effective physician in Native American communities.



SUMMARY

Increases in minority representation in UC medical school classes between 2001 and 2007 have occurred in tandem with the modest increases in the size of the combined pool of medical school matriculants throughout the UC system. However, not all minorities have benefited from these increases. Whites and Asian Americans continue to be represented among UC medical school matriculants at rates higher than their representation in California's population, while Latinos, African Americans, and Native Americans are significantly underrepresented.

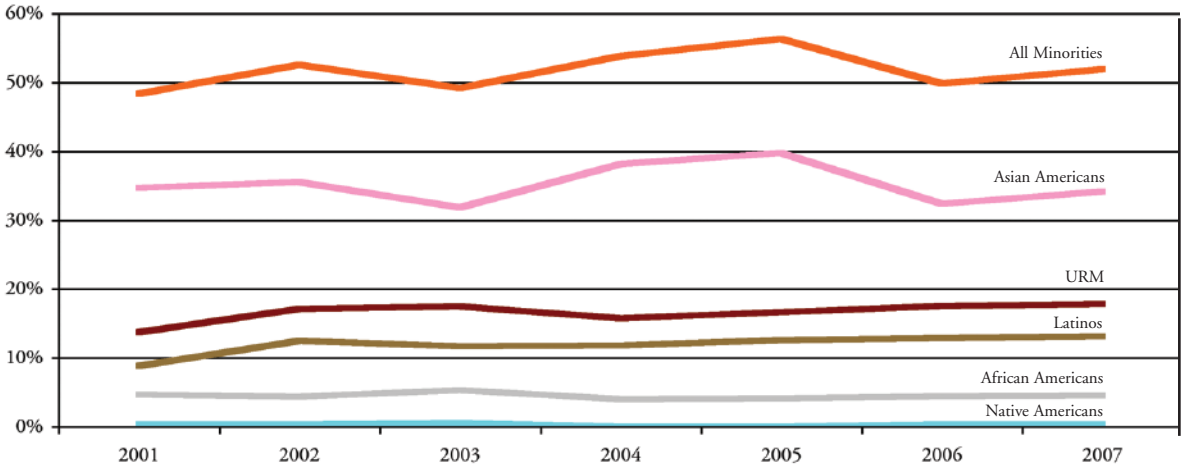
Of these three underrepresented minorities, only Latinos are experiencing any increase at all in their matriculation rates at UC medical schools. However, existing increases in the number of Latino doctors produced by the UC system fail to keep up with the much greater increases in the population of Latinos in California.

FINDING 2: Minority representation in UC medical school programs differs significantly from school to school, and schools with a strong and demonstrated emphasis on attracting diverse applicants and serving underrepresented populations do have a more diverse matriculant pool.

Disaggregating UC medical school matriculation data from 2001 to 2007 by school reveals considerable differences in minority representation from one school to another. Whites are adequately represented at every school, and Asian Americans at every school except at UCLA's joint program with the Charles Drew University of Medicine and Science (UCLA-Drew), which is a historically African American medical school[37]. Of the eight UC medical school programs, only two, UCLA-Drew and UCSF have consistently matriculated African Americans at parity with their representation in California's population. In addition, UCLA-Drew is the only school to matriculate Latinos at parity, and no school has ever consistently matriculated Native Americans every year.

Although the UC medical school system as a whole is failing to produce a diverse medical workforce for the state, these two schools deserve special mention for standing out against otherwise disappointing results.

Minority Representation in UC Medical School Classes 2001-2007, by Race/Ethnicity



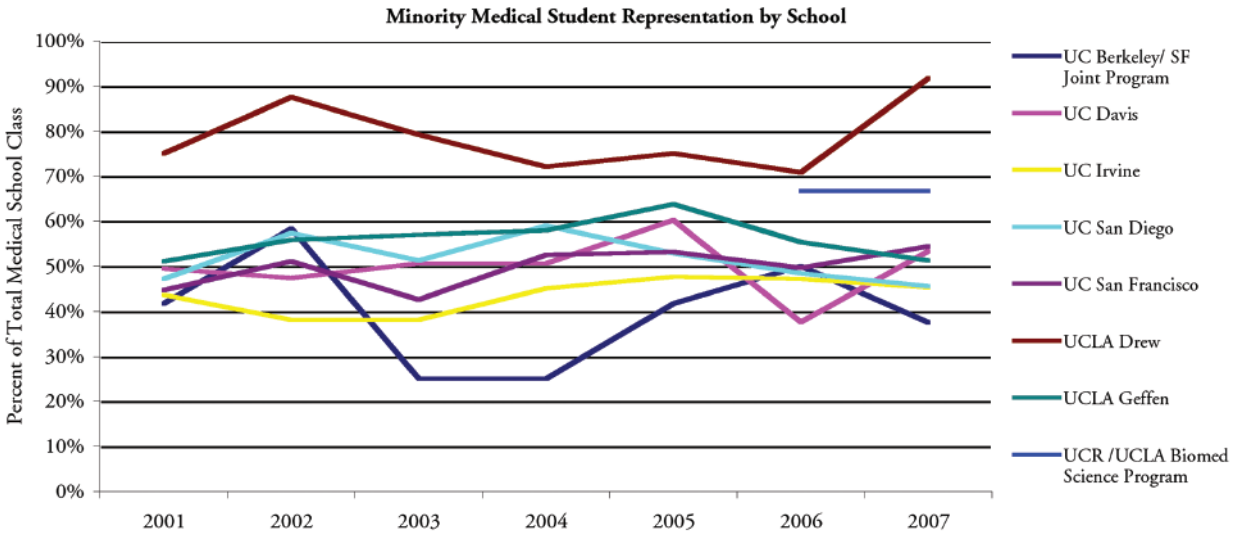
Number of Students

All Minorities	304	330	308	343	360	319	350
URM	86	107	109	100	106	112	120
Asian Americans	218	223	199	243	254	207	230
Latinos	55	78	73	75	80	82	88
African Americans	29	27	33	25	26	28	30
Native Americans	2	2	3	0	0	2	2

Best Performer: UCLA Drew

As the only historically African American medical school in California, it is not surprising that matriculants at UCLA/Drew Medical Education Program have shown consistently high rates of minority representation, with the 2007 class year being comprised of 90% people of color, including 66.7% underrepresented minorities. As a result, the representation of most races at the school is at or above their representation in California's population. This program matriculates the second-greatest number of African American students among its peers, after UCSF.

The UCLA/Drew program is unique among its peer institutions in that its mission statement specifically mentions that a goal of the school is to improve health outcomes for underserved populations, which it does through an innovative residency program that combines general medical education with hands-on training in underserved inner-city communities in Los Angeles. The school is named after Charles Drew, a well-known African American physician. The marked minority presence among the teaching staff and leadership of the school, as well as its location in South Los Angeles and its commitment to serving the underserved all contribute to making UCLA-Drew the most minority-oriented of the UC medical school programs, and the only one in California expressly dedicated to closing the minority health gap.

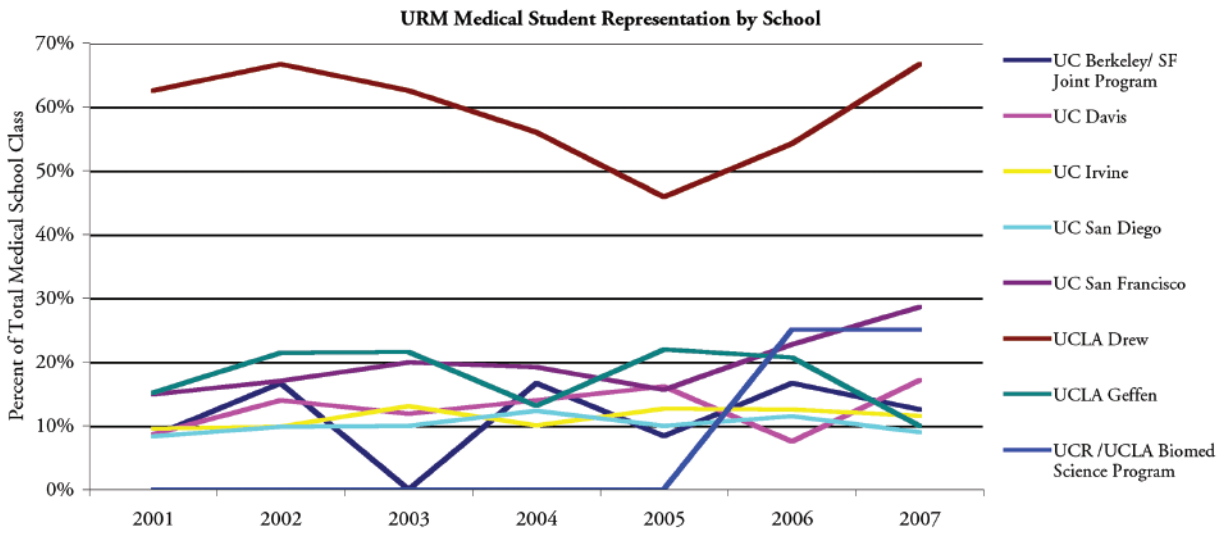


Number of Students

UCB/SF Joint	12	7	3	3	5	6	6
UCD	46	44	47	47	56	35	56
UCI	41	35	35	45	49	49	47
UCSD	57	70	62	72	64	59	61
UCSF	63	72	60	74	75	70	80
UCLA Drew	18	21	19	18	18	17	22
UCLA Geffen	74	81	82	84	93	67	62
UCR/UCLA	0	0	0	0	0	16	16

Most Improved: UC San Francisco

UCSF has shown the greatest increases in African American and Latino representation among its matriculants, compared to its institutional peers. The proportion of African Americans at UCSF has increased from 5% in 2001 to about 8% in 2007, and the proportion of Latinos has more than doubled from about 8% in 2001 to about 18% in 2007. The school also matriculates the largest number of African American and Latino students in the UC system, and is the only school that has had Native American representation in most years. UCSF has not only improved their ethnic/racial diversity in number, but has also emphasized the importance of race in medicine, paying particular attention to racial health disparities.



Number of Students

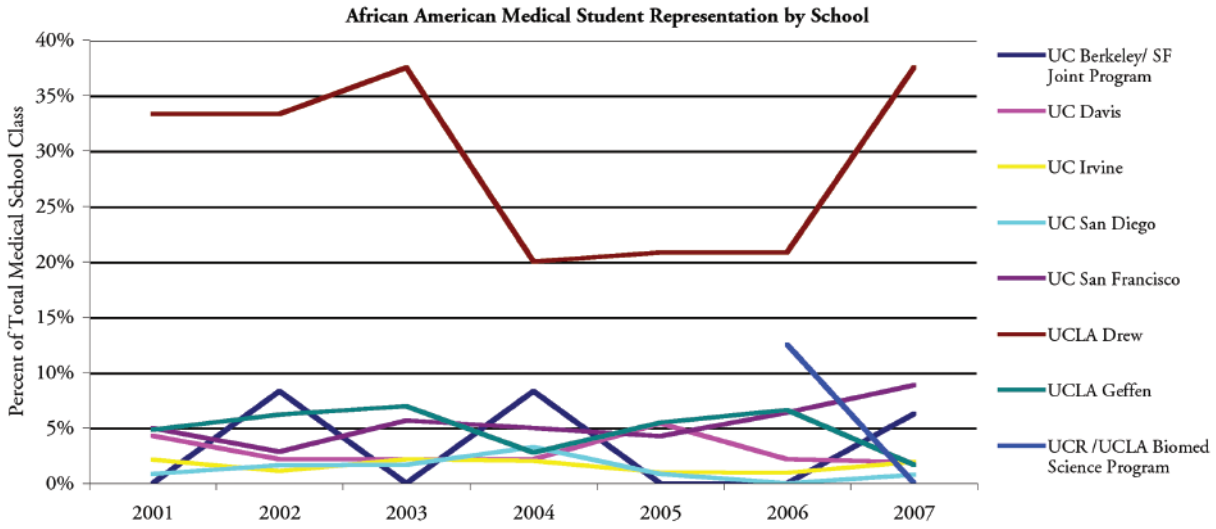
UCB/SF Joint	8	2	0	2	1	2	2
UCD	8	13	11	13	15	7	18
UCI	9	9	12	10	13	13	12
UCSD	10	12	12	15	12	14	12
UCSF	21	24	28	27	22	32	42
UCLA Drew	15	16	15	14	11	13	16
UCLA Geffen	22	31	31	19	32	25	12
UCR/UCLA	0	0	0	0	0	6	6

This commitment to diversity is well-noted among students at the school. One first-year African American student at the school who participated in Greenlining's survey of minority and non-minority medical school students stated that, "From orientation, [UCSF] instilled a sense of pride in our school for having one of the most diverse medical school classes in the country."

During Greenlining's visit to the UCSF medical campus to conduct our interviews, we observed the pronounced difference in diversity between the first and second year classes, which is testament to UCSF's efforts in just that one year to increase diversity at their school of medicine. The first-year class includes 10 more underrepresented minority students than the second-year class, a difference in representation from 22.6% in the second year class to 28.6% in the first year class.

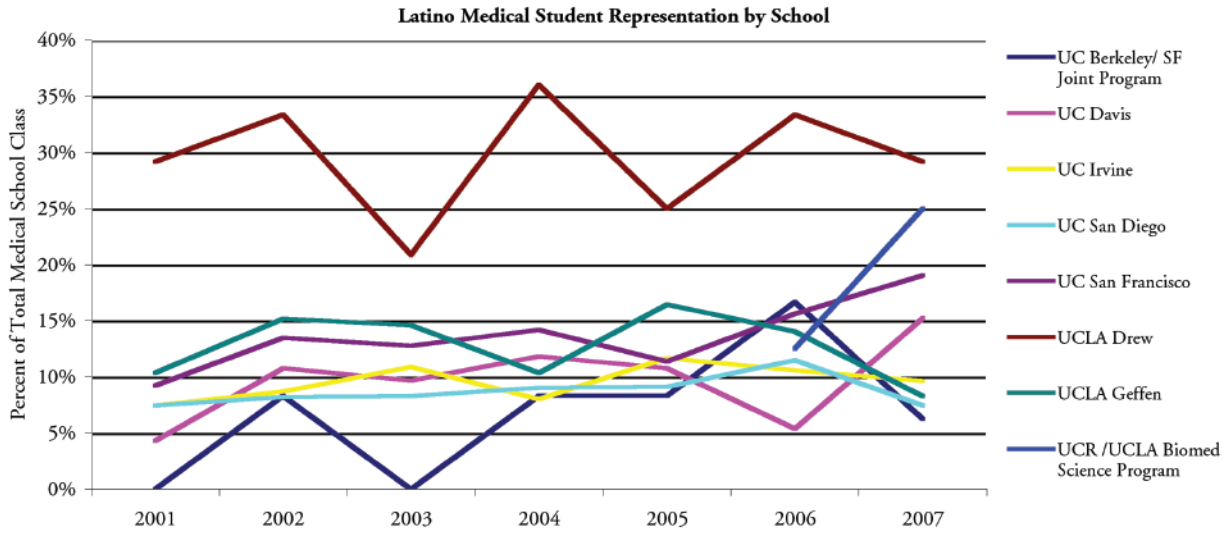
When the first year students were asked questions about the diversity of their medical school, the responses were that diversity is highly valued. From the first week of school, the small group discussions and lunch-time talks put people of different ethnic backgrounds, ages, and experiences together. In these groups, students discuss health disparities. The students realize that diversity is important because the patients that they will eventually serve will be of diverse backgrounds.

Some students feel, however, that the unique diversity of their school may not be used to its fullest capabilities. Some students reported that students of the same race tend to stay within their own groups, challenging the diversity created by the many different backgrounds. Several students reported that they feel that some students will not be interested in diversity issues, and that engagement with diversity rarely goes beyond a few class discussions. Students feel that the class diversity should be utilized to enhance class discussions, as well as the campus climate.



Number of Students

UCB/SF Joint	0	1	0	1	0	0	1
UCD	4	2	2	2	5	2	2
UCI	2	1	2	2	1	1	2
UCSD	1	2	2	4	1	0	1
UCSF	7	4	8	7	6	9	13
UCLA Drew	8	8	9	5	5	5	9
UCLA Geffen	7	9	10	4	8	8	2
UCR/UCLA	0	0	0	0	0	3	0



Number of Students

UCB/SF Joint	0	1	0	1	1	2	1
UCD	4	10	9	11	10	5	16
UCI	7	8	10	8	12	11	10
UCSD	9	10	10	11	11	14	10
UCSF	13	19	18	20	16	22	28
UCLA Drew	7	8	5	9	6	8	7
UCLA Geffen	15	22	21	15	24	17	10
UCR/UCLA	0	0	0	0	0	3	6

The Least Diverse: UC Irvine, UC Davis, and UC San Diego

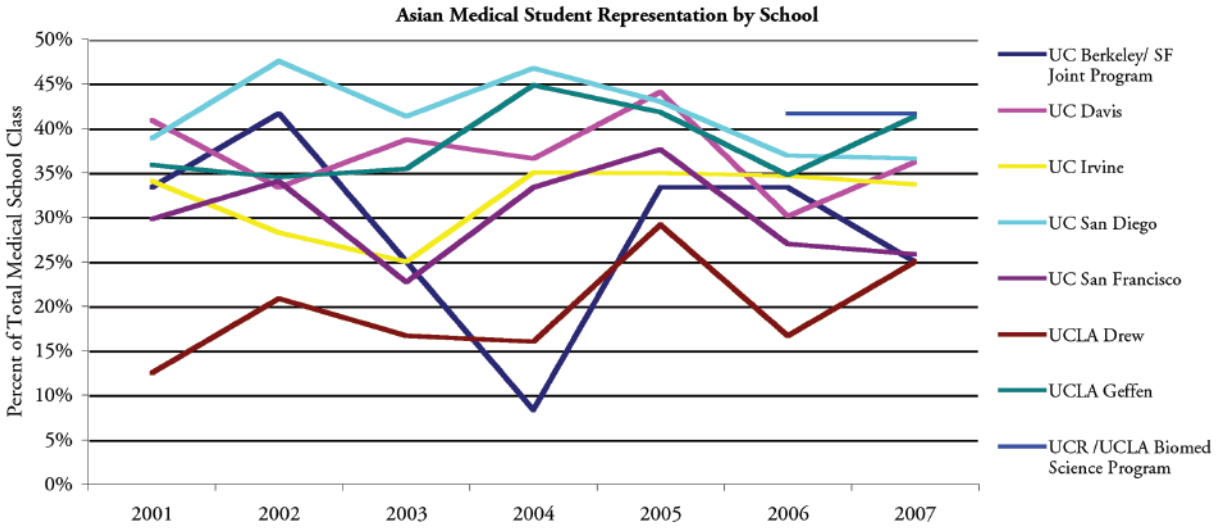
UC Irvine has the lowest proportion of matriculants from underrepresented races/ethnicities among all UC medical schools, with a URM representation rates remaining stagnant at around 11% between 2001 and 2007. In contrast, URM representation at UCSF has been increasing steadily since 2001, and the 2007 class is composed of 28.6% URM. At UC Davis, rates have hovered at around 15%, while at UC San Diego, rates are similar to those at UC Irvine.

UC Irvine

Out of all the UC schools we visited, first and second year students at UC Irvine were the most disappointed with the class and faculty diversity at their school. "We have two African American students and only about ten Latino students in our class," a first year non-minority student complained. She continued, "a lack of diversity hurts everyone, not just minority students." The general consensus was that though there are a couple of well-represented minority groups present (East Asians and South Asians, specifically), URM enrollment is very low.

A first year Latino student spoke of his experience as disappointing: "It was shocking to see the low number of minorities in my class and makes me question how important diversity is to UCI." Many students share his sentiments. Though the school's minority student population and students in the PRIME program[38] are genuinely passionate about increasing racial/ethnic diversity, they feel that the school does not have the same priority. Another first year Latino student continued, "It seems as if the school's leaders put almost no effort towards recruiting minorities to increase diversity."

Most damaging, UCI has no diversity affairs office. Students who are interested in increasing diversity do most of the work in recruiting minority students. Understandably, keeping this balance between recruiting minority students and being a student is overwhelming; a first year Latino student we interviewed said that he feels that he is both "a student and a diversity outreach person."



Number of Students

UCB/SF Joint	4	5	3	1	4	4	4
UCD	38	31	36	34	41	28	38
UCI	32	26	23	35	36	36	35
UCSD	47	58	50	57	52	45	49
UCSF	42	48	32	47	53	38	38
UCLA Drew	3	5	4	4	7	4	6
UCLA Geffen	52	50	51	65	61	42	50
UCR/UCLA	0	0	0	0	0	10	10

"The first day of class, I did not know what to expect. I came in with such unease. When I looked around the room, I felt more comfortable because there was a group of people that looked like me."

–Second Year Latina Student, UCLA

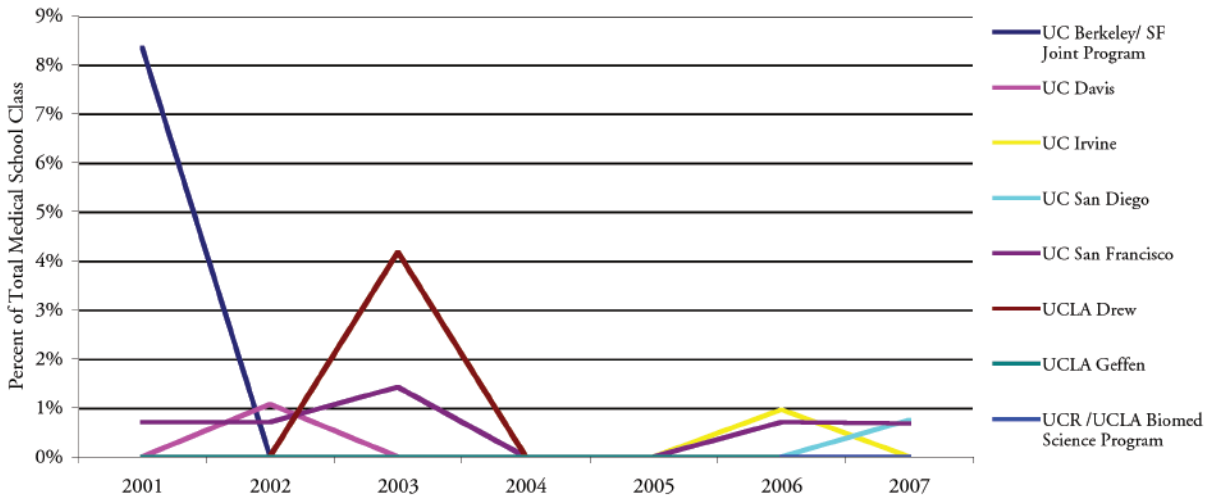
All students who volunteered their time to complete the face-to-face interview were interested in improving diversity at UCI. When asked how diversity had impacted their class discussions, the students overwhelmingly expressed that because there is no diversity, there are no class discussions around cultural differences except within student organizations. One student asked, "How can we learn to care for a population as diverse as California's without input and interaction in a school setting?"

Nonetheless, the students we interviewed seemed to be determined to make a difference over the next few years: "Unfortunately, our class will not enjoy the benefits of diversity, but hopefully over the next five years, our efforts to increase the number of underrepresented minorities will be realized," said a very frustrated first year Latina student.

UC Davis

Students at UC Davis also reported being disappointed by the diversity at their school. The sentiments of all the students we interviewed there were very similar: not enough was being done at UC Davis to increase minority enrollment and to improve the dialogue within classes between students of different racial and ethnic backgrounds.

Native American Medical Student Representation by School



Number of Students

UCB/SF Joint	1	0	0	0	0	0	0
UCD	0	1	0	0	0	0	0
UCI	0	0	0	0	0	1	0
UCSD	0	0	0	0	0	0	1
UCSF	1	1	2	0	0	1	1
UCLA Drew	0	0	1	0	0	0	0
UCLA Geffen	0	0	0	0	0	0	0
UCR/UCLA	0	0	0	0	0	0	0

We found that at UC Davis most of the minority medical students sat together in the class. A second year African American female student's thoughts supported our observation that within the class, students of color were more likely to engage in conversation focused on diversity (socially and academically) with each other. "I feel that here [at UCD], the minority students are isolated," she continued, "I feel like we're in it alone. If there was one thing I would change, it would be the flavor of the social environment."

As part of the curriculum, in an effort to improve discussion around diversity, the school showed the 1994 race-conscious film *The Color of Fear* to all students prior to winter finals. The students expressed that, though the exercise was done with "good intentions", the movie actually created a lot of tension within the class. There were a few "very heated" discussions involving race. One student commented that as the only minority in her group, she was "fearful of speaking out" because she felt there would be "repercussions." Another student said that, "the deans are concerned with diversity, and it is evident that they are committed to making UC Davis more diverse; however there is a great lack of awareness [among our] classmates." She felt that the overall feeling of her fellow classmates was an indifference towards diversity issues, as shown through their ignorant comments in and outside of class.

A second year Latino student discussed how "stressful and difficult" it was for him to assimilate into his class. He felt that he could not relate to his classmates and that the lack of discussion concerning racial differences and cultural awareness contributed to his feelings of isolation.

A second year non-minority female student also mentioned that there was a lack of discussion around issues of diversity. Though she was content with the improvements made in the first year's class, she felt that UC Davis medical school as a whole was not as diverse as it should be.

For a minority, I think it is important have people in class who look like you. For distinct issues, you want someone to relate to you."

–Second Year Non-Minority Student, UC Davis

2007 RANK IN PROPORTION OF ALL MINORITY MATRICULANTS

Rank	UC Medical School Program	Percent
1	UCLA-Drew	91.7%
2	UCLA-UC Riverside	66.7%
3	UC San Francisco	54.4%
Minorities in California's Population		*54.0%*
4	UC Davis	53.3%
5	UCLA-Geffen	51.2%
6	UC San Diego	45.5%
7	UC Irvine	45.2%
8	UC Berkeley–UCSF Joint Program	37.5%

2007 RANK IN PROPORTION OF UNDERREPRESENTED MIN. MATRICULANTS

Rank	UC Medical School Program	Percent
1	UCLA-Drew	66.7%
URM in California's Population		*48.0%*
2	UC San Francisco	28.6%
3	UCLA-UC Riverside	25.0%
4	UC Davis	17.1%
5	UC Berkeley–UCSF Joint Program	12.5%
6	UC Irvine	11.5%
7	UCLA-Geffen	9.9%
8	UC San Diego	9.0%

2007 RANK IN PROPORTION OF AFRICAN AMERICAN MATRICULANTS		
Rank	UC Medical School Program	Percent
1	UCLA-Drew	37.5%
2	UC San Francisco	8.8%
3	UC Berkeley—UCSF Joint Program	6.3%
African Americans in California's Population		*6.0%*
4	UC Davis	1.9%
4	UC Irvine	1.9%
5	UCLA-Geffen	1.7%
6	UC San Diego	0.7%
7	UCLA-UC Riverside	0.0%

2007 RANK IN PROPORTION OF LATINO MATRICULANTS		
Rank	UC Medical School Program	Percent
Latinos in California's Population		*41.0%*
1	UCLA-Drew	29.2%
2	UCLA-UC Riverside	25.0%
3	UC San Francisco	19.0%
4	UC Davis	15.2%
5	UC Irvine	9.6%
6	UCLA-Geffen	8.3%
7	UC San Diego	7.5%
8	UC Berkeley—UCSF Joint Program	6.3%

Diversity Breeds Diversity: UCLA-Geffen

In response to the interviews of students we conducted at Geffen we received a general consensus that not many minorities apply to UCLA because recruitment is not as strong as it should be. A second year African American student suggested that more attention should be placed on mentorship and encouraging local high school students and undergraduates interested in medicine to apply to UCLA. "The administration could do a better job of getting students involved and letting them know more about [UCLA's] program and the resources available," she explained. She also felt that more non-minority students should get involved in diversity related activities, like putting on Health Fairs, which are typically organized only by underrepresented minority students.

Curriculum changes should accompany the improved diversity. Our curriculum does not do the best job of using our diverse class."

–First Year Asian American Student, UCSF

A second year African American student reiterated the importance of recruiting: "No one in the Bay Area knows that UCLA wants to diversify its student body." He continued, "Admissions is making a trying effort, but underrepresented minorities are just not applying. Something must be done!" Another second year African American student affirmed that minority students are not attracted to UCLA because they see a lack of diversity in the classes: "when people see more diversity," she argued, "they'll be more likely to come to school here."

Though the first year class (entering 2007) is the least diverse class UCLA has had, matriculating only 62 minority students compared to an average of 80 from 2001 to 2006, one first year African American student described his experience as a UCLA medical student as "great" because he came through the Office of Outreach. In fact, a large majority of minority students, particularly those in the PRIME program, expressed gratitude for the support and insight provided by the Office of Academic Enrichment.

2007 RANK IN PROPORTION OF ASIAN AMERICAN MATRICULANTS		
Rank	UC Medical School Program	Percent
1	UCLA-UC Riverside	41.7%
2	UCLA-Geffen	41.3%
3	UC San Diego	36.6%
4	UC Davis	36.2%
5	UC Irvine	33.7%
6	UC San Francisco	25.9%
7	UC Berkeley—UCSF Joint Program	25.0%
7	UCLA-Drew	25.0%
Asian Americans in California's Population		*13.0%*

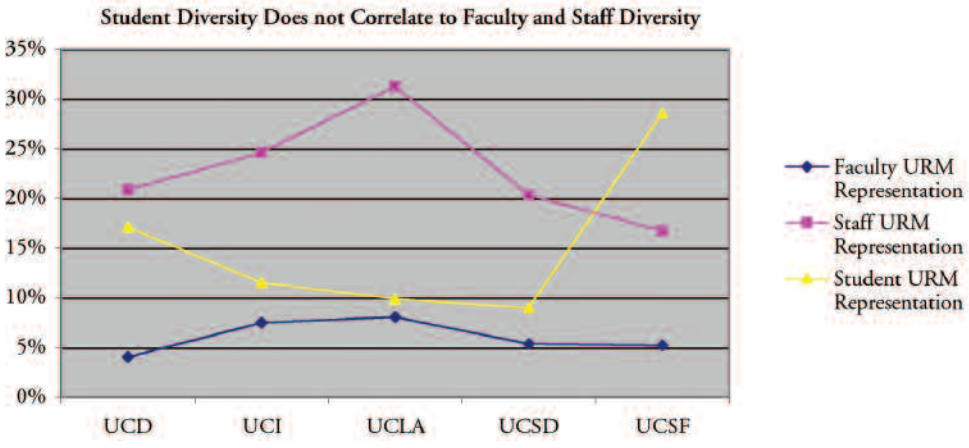
2007 RANK IN PROPORTION OF NATIVE AMERICAN MATRICULANTS		
Rank	UC Medical School Program	Percent
Native Americans in California's Population		*1.0%*
1	UC San Diego	0.7%
1	UC San Francisco	0.7%
2	UC Berkeley—UCSF Joint Program	0.0%
2	UC Davis	0.0%
2	UC Irvine	0.0%
2	UCLA-Drew	0.0%
2	UCLA-Geffen	0.0%
2	UCLA-UC Riverside	0.0%

Holistic Diversity: The Faculty and Staff Connection

The first two reports in Greenlining's *Representing the New Majority* series (of which the present report is the third) looked at staff and faculty diversity at the UC medical school campuses, separately. Comparing the best performing schools across all three of our reports, we find that while comparative URM representation rates for faculty and staff among the five medical school campuses follow a predictable pattern; rising and falling relative to one another, URM representation among students does not follow this pattern.

The graph below represents data for the last years for which Greenlining published data. Staff diversity data is from 2002, faculty diversity data is from 2004, and student diversity data is from 2007. We can observe that UC medical schools with more diverse faculty are also the ones with more diverse staff, which shows consistency in hiring practices. For students, however, the pattern does not hold.

Further research will have to be conducted to explain why UC medical schools show continuity in their faculty and staff diversity hiring practices, yet show no such continuity in admissions.



SUMMARY

Due to the small numbers of underrepresented minority students who matriculate each year, most schools show considerable fluctuation in the percentages of minority students who matriculate each year, so it is difficult to make any generalizations about diversity trends at specific schools. It is clear, however, that the lack of emphasis on diverse recruitment and failure to expand enrollment at the medical schools both contribute to the UC medical school system's failure to produce a diverse physician workforce that is equipped to effectively address the current and emerging challenges in providing healthcare to an increasingly diverse state.

In addition, student responses in our interviews show that students value diversity for its role in increasing awareness of how health impacts diverse communities, and increasing students' ability to interact with people of diverse races, a skill essential to any practicing physician. Both minority and non-minority respondents mentioned that this type of interaction is an essential part of their medical education.

Lack of diversity creates an environment that isolates minority students and increases segregation, thereby reducing the educational value of having a diverse medical school class. We could see signs of this feeling of isolation both in student responses and in the physical segregation of the various minority groups in voluntary class seating arrangements. One UC Davis student summed it up succinctly: "I feel like underrepresented minorities are in it alone in the classroom and socially."

Medical schools that do have diverse classes should ensure that their curricula tap the cultural knowledge of their student bodies in order to truly make diversity work for students of all backgrounds. A curriculum that emphasizes the effect of racial and ethnic health disparities, the effect of location and upbringing on health outcomes, and the special health needs of poor communities would effectively use the knowledge capital that underrepresented minority students have to offer.

FINDING 3: Insufficient numbers of minorities are applying to medical school. The representation of minority groups in the overall pool of applicants to UC medical school programs is very similar to their representation among the matriculants. Medical schools are accepting students of diverse backgrounds in proportion to the rates at which they apply.

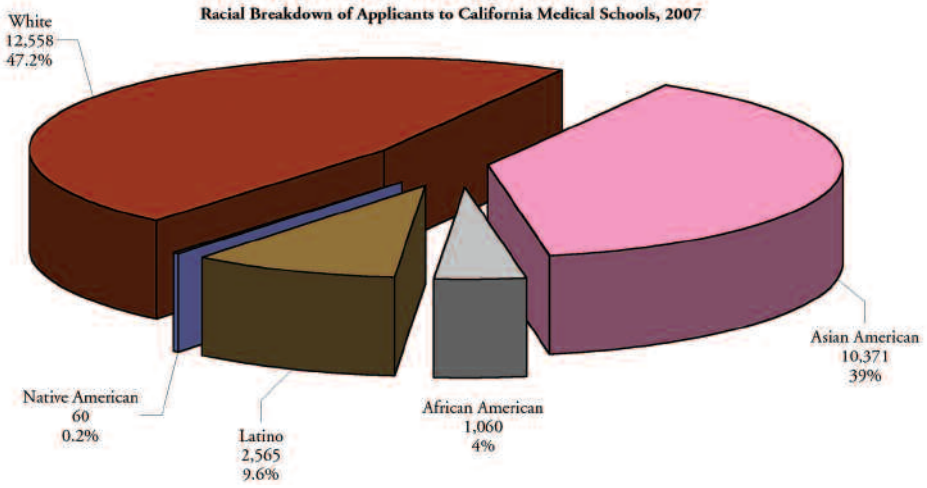
The lack of diversity at UC medical schools is a grave threat to the state's ability to provide quality and culturally competent care to an increasingly diverse population. This lack of representation is partly, but not entirely a product of insufficient diversity practices within the University of California.

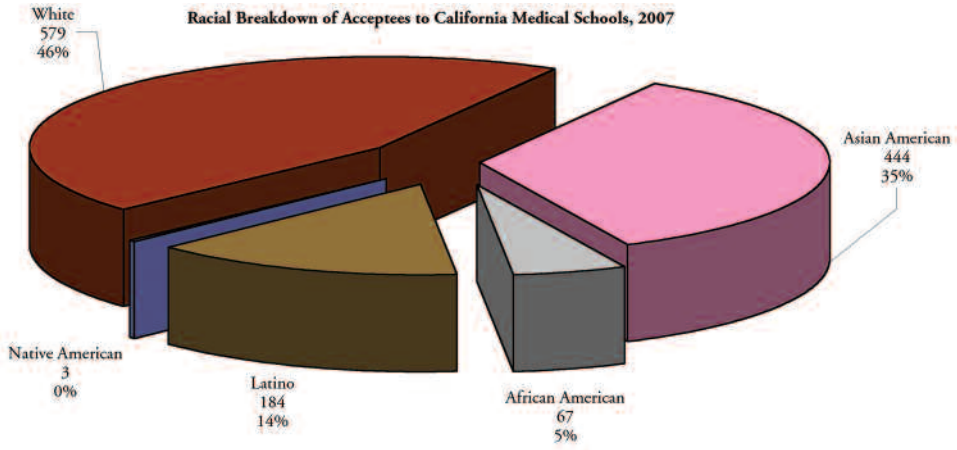
The increasing representation gap experienced by Latinos, African Americans, and Native Americans is also due to issues present before the student applies to medical school, such as lack of proper academic preparation in elementary and middle schools, greater high school and college dropout rates among underrepresented minorities, and lesser financial wherewithal in many families from underrepresented communities to attend college and medical school.

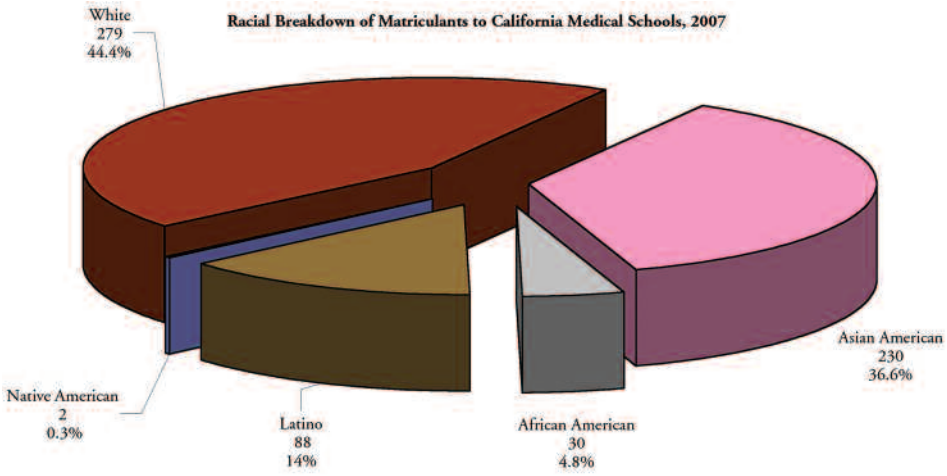
As the following figures show, data on the diversity of the applicants, acceptees, and matriculants to UC medical schools shows that there is very little difference in the representation of particular minority groups in their representation at each level of the application process. In fact, the proportions of underrepresented minorities among matriculants is even slightly higher than their share among the applicants. This observation is consistent among all the years studied, 2001-2007. Medical schools are accepting students of diverse backgrounds in proportion to the rates at which they are submitting applications, and the problem of low minority enrollment is due to insufficient numbers of minorities applying to medical school.

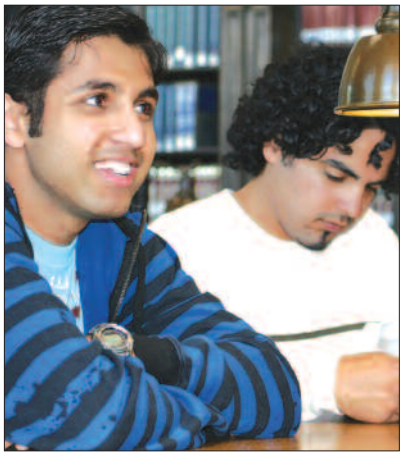
This finding is a strong indicator that in order to increase minority enrollment we need to look earlier in the health professions educational pipeline to find opportunities to create a larger pool of minority applicants to medical school. Such opportunities include efforts to reduce college and high school dropout rates and supporting enrichment programs that encourage diverse students to enter and stay in the health professions educational pipeline.

However, the aggregate does not explain the variations in minority recruitment among individual UC medical schools. While much needs to be done to improve education in minority communities across the state in order to prepare more underrepresented minorities for medical school, the schools themselves also bear a responsibility to actively recruit and attract minorities, and to give the opportunities and challenges that arise from serving diverse patients their due importance as central themes in a prospective physician's education.









FINDING 4: The positive effect of the University Regents' 2001 decision to rescind SP-1 can serve as a model to what would happen if Proposition 209 were repealed.

In 1995, the Regents of the University of California passed Standing Policy 1 (SP-1), which barred the use of racial or ethnic considerations in admissions criteria. The impetus behind organizing support for this policy came from former regent Ward Connerly, who also spearheaded the effort to put Proposition 209 on the ballot in 1996. Both Proposition 209 and SP-1 had an effect on minority enrollment at the University of California, and our analysis of historical data on minority matriculation rates found that the UC Regents' decision to repeal SP-1 in 2001 had a positive effect on minority enrollment at UC medical schools, which may foreshadow the greater increases in minority representation that may be possible if Proposition 209 were reversed.

Matriculation rates for most underrepresented minority groups had been declining since their peak in 1993 or 1994 by the time both policies were passed, and continued to decline since then until after 2000, when they began a modest increase, especially among Latinos.

This decline can be attributed partly to the deterioration of the Association of American Medical Colleges' nationwide program to increase URM enrollment in medical school, Project 3000 by 2000, which sought to increase underrepresented minority enrollment in medical school from just under 1,500 in 1990 to 3,000 by the year 2000. The program did not meet its numeric goals, although it did succeed in bringing the issue of the importance of diversity to the medical field to the forefront. It is not unreasonable to conclude that the anti-affirmative action laws passed in California (the state with the largest URM population among all US states) during the mid-1990s led to the failure of the program to achieve numeric goals.

The increase in URM enrollment after 2001, the trends of which are studied in Findings 1 through 3 in this report, is the most significant indicator for assessing the effect of Proposition 209 and SP-1 on minority enrollment in the UC medical schools. Although Proposition 209 is by far the most infamous of the two laws, the repeal of SP-1 in May of 2001 seems to have had a positive effect on minority enrollment at UC medical schools in the last seven years.

In order to place the data from 2001 to 2007 that we present in this report into context, and in order to track the effect of SP-1, we incorporated into our analysis data on applicants, acceptees, and matriculants at the UC medical schools found in the *Special Report on Medical Student Diversity* published in November 2000 and prepared by the Medical Student Diversity Task Force.

We found that although matriculation trends for each underrepresented racial and ethnic group differ, they all have one point in common: their numbers among applicants, acceptees, and matriculants began a trend of steady increase after the repeal of SP-1 in 2001 after significant declines throughout the 1990s. In the case of Latinos and Asian Americans, the gains between 2001 and 2007 offset the declines of the 1990s, while African Americans and Native American numbers never recovered from their peaks in the early–to mid–1990s.

African Americans

The number of African American matriculants in UC medical school programs has dropped 6.5% since 1990. Numbers of African American applicants, acceptees, and matriculants peaked in 1993 and 1994, then decreased dramatically until 2000, when the numbers of African Americans among matriculants was slightly less than half what they were during the peak. After the repeal of SP-1, the number of African American matriculants rose slowly, yet steadily, so that current numbers are 36% below their peak. If these trends continue, the number of African American matriculants should surpass the 1993 peak in about ten years.

Latinos

Latinos have made continued progress towards increasing their numbers at UC medical school programs, and have apparently benefited the most from the repeal of SP-1. There are currently 29% more Latino matriculants than in 1990. Like the number of African American matriculants, the number of Latino matriculants hit bottom in 2000 but then rose an unprecedented 72.5% since 2001. If these trends continue, the number of Latino matriculants should surpass the 1992 peak in about two years. Despite these advances however, Latino representation is not keeping up with increases in their population among California residents, and the UC must continue to expand its efforts to increase student representation of California's fastest-growing ethnic population.

Native Americans

Native Americans have always had extremely low representation among UC medical school matriculants. The highest number of Native Americans in any one year was in 1996, when all UC medical schools had 6 Native American students, collectively. Even so, the number of Native American students among UC medical school matriculants averaged at around 4 students prior to 1996 and averaged at 2 students after 1996.

Asian Americans

The representation of Asian Americans among matriculants has increased steadily since 1990, with current representation rates in 2007 at 17% above that in 1990. The trend seems unaffected by either Proposition 209 or by SP-1.

Whites

White representation among UC medical school matriculants has actually declined since 1990, with the 2007 level at 7% below that in 1990.

All Minorities

Aggregate representation of African Americans, Latinos, Asian Americans, and Native Americans has increased steadily since 1990 with Asian Americans leading the way. Applications from minorities peaked in 1995, then decreased until 2003. Minority applicants have increased their representation among all applicants by 85% since 1990, which brings current applicant levels to only slightly below their peak levels in 1995.

The number of minority matriculants is higher than ever, with 2007 levels 18.6% above those in 1990. These trends however, are heavily influenced by the large and steadily growing number of Asian American matriculants in UC medical schools.

Underrepresented Minorities

If we remove Asian Americans from the analysis, who are adequately represented among UC medical school matriculants relative to their representation in California's population, we find that the number of African American, Latino, and Native American matriculants follows the trend for Latinos: peaking in 1992, then declining precipitously until reversing course in 2001. Current matriculation numbers for URM are 15.4% above 1990 levels, yet 14.3% below the 1992 peak. If current trends continue, the number of URM matriculants should surpass the 1992 peak in about five years.

Total Representation

Class sizes at UC medical schools are only 6% above 1990 levels. Given that the population of California (and therefore the population of potential patients) has increased 8% in the same time period, it is clear that the UC is not producing sufficient doctors of any race to keep up with current need. Applications to UC medical schools are currently 48% above their levels in 1990, which is only slightly below the peak levels in 1995.

Item number 2 in the resolution unanimously passed by the Regents of the University of California that rescinded SP-1 and SP-2 (RE-28), states that "the University shall seek out and enroll, on each of its campuses, a student body that demonstrates high academic achievement or exceptional personal talent, and that encompasses the broad diversity of backgrounds characteristic of California.[39]" This statement made in the public record is no less than a commitment to the citizens of California that the University will seek to serve each racial and ethnic population in the state at a level commensurate with their representation in the total state population. While the data on underrepresented minority enrollment show that the Regents have been making progress on this commitment, we stress that much more needs to be done to bring the diversity of UC medical schools up to parity with the diversity of the state.

Importantly, judging from the positive effect that rescinding SP-1 had on minority enrollment, *how much more can diversity be bolstered if California voters recommit to increasing diversity in our institutions of higher education and repeal Proposition 209?*

FINDING 5: Although Proposition 209 has certainly contributed to depressing URM enrollment at the University of California medical school programs, the UC still has many avenues it can pursue in increasing minority enrollment while not overstepping the boundaries of the law.

The second major legislative hurdle in increasing the numbers of underrepresented minorities among UC medical school matriculants is California Proposition 209, which when adopted by the Legislature in 1996 represented the abolition of affirmative action in the state of California. The issue of the extent to which Proposition 209 has affected the rates of matriculation of URM at UC medical schools is a nuanced one that is not readily explained by one simple numeric measure or another.

As discussed in Finding 4, the Regents' decision to rescind SP-1 in 2001 had a positive effect on URM matriculation at UC medical schools. We expect that repealing Proposition 209 would have a similar, if not a greater effect on the number of URM who apply, are admitted to, and matriculate in UC medical schools.

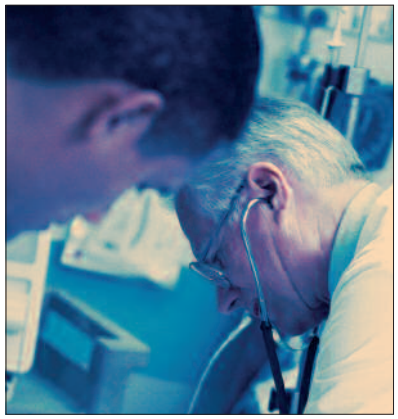
Even so, repealing Proposition 209 represents an important first step in increasing student diversity, yet there is much more work to be done beyond this. Repealing Proposition 209 may help students who are at the threshold of entering college or entering medical school, but will do nothing for the 43% of Latino and 44.7% of African American Californians who drop out of high school every year.[40]

Recommitting the people and the Legislature of California to diversity in our institutions of higher learning by repealing Proposition 209 must be achieved *in tandem* with other, further-reaching, and more specialized efforts to increase minority enrollment, such as increasing outreach to underserved communities, strengthening and expanding pipeline and post-baccalaureate programs, and paying close attention to demographic changes that present opportunities for community and institutional leaders to make a positive impact.

However, as we discussed in Finding 4, there have been marked increases in URM enrollment at UC medical schools since the repeal of SP-1 in 2001. The repeal of this policy did not only represent a retreat from the anti-affirmative action trend started in the mid-1990s, but also the beginning of more nuanced efforts to increase minority enrollment. That said, there are many more possible causations that may have contributed to recent increases in URM enrollment. Some of these are demographic changes, but many of the others represent some change in policy on the part of the University of California to increase diversity.

Policy Changes

The following represent changes in the University of California's policy towards diversity since 2000 that may have contributed to the increase in minority enrollment in addition to the repeal of SP-1. Further research will reveal the extent to which any or all of these policy changes contributed to the steadily increasing diversity at the UC medical schools.



1. Increased outreach from UC medical schools to URM applicants.

Direct outreach by medical schools, which can range from direct communications from the president, which Richard Atkinson had done from 1999 to 2000 in an effort to increase minority enrollment, to direct student-to-prospective student outreach, as the minority students we interviewed at UC Davis had done. Outreach efforts like these reinforce a sentiment among potential URM medical school applicants that their presence at the schools is desired, which can do much to motivate students to pursue the preparation necessary to continue in a pre-medical track of study.

2. Increased incentives for minority enrollment in non-UC medical schools.

The UC system is competing with all other medical education programs in the country for top students. The UC must ensure that its medical schools remain the programs of choice for diverse prospective students.

3. Expansion and increased success rates of pre-baccalaureate and pipeline programs that target minority students.

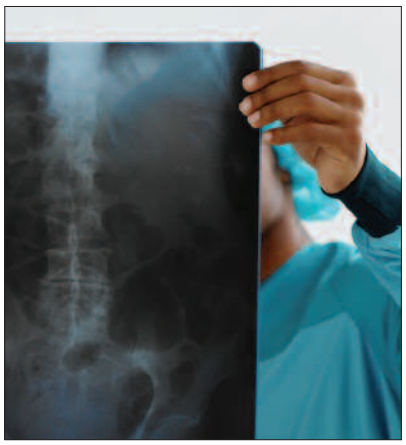
These programs are essential for bringing students from disadvantaged backgrounds up to par for consideration for admission into medical school. The existence and promotion of these programs is also likely to influence more URM students to consider a career in the health professions and to further their education at a medical school.

4. Increased total enrollment numbers at UC medical schools.

Total enrollment at UC medical schools has increased only 6% since 1990. Increasing enrollment will expand California's capacity for training future physicians, and may also increase the number of physicians who practice in California.

Demographic Changes

The following are demographic changes in California that may have also contributed to increasing minority medical school enrollment. Further research will also reveal the extent to which each of these factors may have contributed to the increase, and will also provide recommendations as to what steps the University can take to take advantage of these changing demographics to bolster diversity.



1. Decreased enrollment by White students into UC medical schools.

The number of non-Hispanic Whites in California's population has decreased by 10% from 1990 to 2007. The representation of Whites at UC medical schools has also decreased in that time in tandem with the slight increase in minority representation. Even so, Whites are still adequately represented at UC medical schools.

2. Demographic changes that increased the number of Latinos and African Americans in the college-age range.

Such shifts would naturally swell the ranks of these racial and ethnic groups among undergraduates and increase the probability that more African Americans and Latinos will be among the students who choose to enter medical school. The UC should take advantage of ongoing demographic shifts to ensure that its programs are educating a future health workforce that is as diverse as the population of the state.

3. Decreasing high school dropout rates among URM that have increased the ranks of URM among college students.

African American high school completion rates have been increasing since the Civil Rights Era, and Latino rates have been increasing since the mid-1990s.[41] Yet the completion rates of both URM groups remain lower than those for Whites and Asians. Enrichment programs that keep URM students in school are a necessary element in curbing such early leaks of URM students in the health professions educational pipeline.

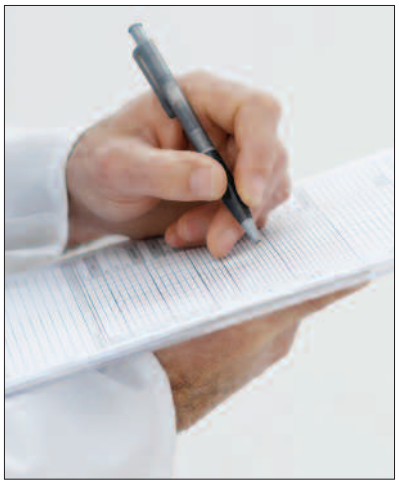
4. Cultural or economic changes that increased the relative attractiveness of medicine as a career versus one in business, law, information technology, or other popular fields.

The University of California has a responsibility to promote a medical education as a solution to the health disparities among racial and ethnic populations in the state, and to emphasize that a diverse health workforce is essential to extending the reach of quality medical care to all communities regardless of race, income, or geography. As such, the promotion of medicine as an attractive and useful course of study should be a major goal of the University of California in tandem with increases in the capacity of medical schools if it is to produce more doctors to serve a growing population.

All of these possible causations deserve to be the subjects of future research. However, assuming that any or all of these causations have indeed influenced the recent increases in minority matriculation at UC medical schools, we should be mindful of the common thread among all of these possibilities. All of them, except the demographic shifts, involve targeted efforts to increase the number of URM in the health professions educational pipeline. This means that in order to be truly effective in increasing diversity at UC medical schools, change must come from both the top and the bottom; from eliminating anti-diversity policies and laws, to empowering underserved communities with the information and resources they need to stay in the health professions educational pipeline.

RECOMMENDATIONS

In light of our findings in this report and the evidence in the literature on the importance of diversity in medical education and trends in minority representation in UC medical schools, the Greenlining Institute presents the following recommendations to the Association of American Medical Colleges, the California Legislature, the Board of Regents of the University of California, the directors, administrators, and faculty of individual UC medical schools, community leaders, and other parties who recognize the importance of producing more minority doctors from the UC medical schools and *are willing to take action to make it happen.*



1. The University of California should increase enrollment numbers by expanding existing programs and by opening new medical schools.

A medical school at the new UC Merced campus, for example, would be in a prime location to be able to focus on health care issues focused on the needs of rural and Latino Californians. Existing joint programs should be expanded into full medical schools that keep diversity as one of their primary objectives.

2. Admissions policies should place greater weight on applicants' demonstrated commitment to serving the underserved, as well as cultural and linguistic competency.

The qualities and skill sets needed to be a "good" doctor go far beyond academic achievement, and include measures such as compassion, sensitivity, and inclination to serve the underserved. As mentioned in this report, the fact that minority physicians are much more likely to effectively serve poor, underinsured, or minority patients, is supported by both substantial research and myriad anecdotal evidence, such as the example stated in the introduction to this report of the clinic in Los Angeles that serves Mayan patients.

cont. next page

"We are ill-equipped as future physicians without diversity."

–First Year Non-Minority Student, UC Irvine

3. Medical school curricula should incorporate diversity, not operate irrespective of it.

A curriculum that emphasizes the effect of racial and ethnic health disparities, the effect of location and upbringing on health outcomes, and the special health needs of poor communities would effectively use the knowledge capital that underrepresented minority students have to offer their peers. These efforts should include creating an institutional culture that is comfortable with conversations around diversity and engaging in serious discussions around the realities and challenges of delivering quality healthcare to an increasingly diverse population.

4. The University of California should increase efforts to recruit a diverse applicant pool by expanding its post-baccalaureate and pipeline programs, conducting outreach to minority communities, and by ensuring adequate financial support for enrollees.

These efforts would minimize the number of health career-tracked URM students who become discouraged from pursuing medical school, or who fall behind in preparing themselves for medical school.

5. The University of California should develop materials to help middle and high school teachers and guidance counselors inform students about opportunities in the health workforce, and about available pipeline programs.

Sometimes all it takes to encourage a student to pursue a career in the health professions is to empower them with information and to nurture a budding interest. Middle and high school is an ideal time to recognize URM students who are interested in the health professions and then encourage and prepare them to enter medical school.

6. The AAMC should collect and publish data on Asians and Pacific Islanders that disaggregates this very heterogeneous group into its constituent ethnicities.

Aggregating all API ethnic groups into a single category masks the considerable variation in the health outcomes and student representation among various Asian ethnic groups. Presenting disaggregated data will reveal these inequalities.

7. The University of California should increase diversity among faculty and staff on all levels.

This will create an environment that is more welcoming to minority students and will reduce many URMs' feeling of isolation. Ironically, there is a loose correlation among staff, student, and faculty diversity within the same

schools, as Greenlining has reported in the previous two sections of our *Representing the New Majority* report series. UC medical schools should take into account the value of adding diversity as part of their benchmarks in both hiring and admissions practices.

8. The University of California should increase efforts to matriculate admitted URM students.

These efforts may include offering attractive financial aid packages, or having minority faculty do direct outreach to minority acceptees to encourage them to enroll.

9. All UC medical schools should have an office or department of diversity and minority affairs.

This office should be in charge of diversity recruitment, support of minority students already enrolled, and ensuring that the school's curriculum is incorporating diversity.

"My experiences have been enlightening being in diverse classes, including students from different career paths and ethnic backgrounds."

–Second Year Asian American Student, UCSF

10. The members of the admissions committees at all UC medical schools should be as racially and ethnically diverse as possible, and should also be diverse in terms of their members' areas of practice and expertise.

Maximizing the diversity of the admissions committees of each school can increase the number of URM applicants that are admitted by having application readers who will recognize the value of the backgrounds of individual applicants to the quality of education at their institutions.

11. The University of California Office of the President (UCOP) should collect and publish data on the diversity of UC medical school students, faculty, and staff annually.

This data should be made public so that community groups and other interested parties can evaluate the extent of the UC's progress on increasing its diversity.

12. The California Legislature should submit a referendum to repeal Proposition 209.

Judging from the positive effect that rescinding SP-1 had on minority enrollment, how much more can diversity be bolstered if California voters recommit to increasing diversity in our institutions of higher education and repeal Proposition 209? Our state leaders should recommit their support of the state's underrepresented communities by working to repeal legislative barriers to increasing diversity.

CONCLUSION

In a time when the state budget crisis is limiting resources available for public welfare, there is an increased need to ensure accountability and effectiveness in programs and policy changes intended to increase diversity in the UC medical schools. While some recommendations such as creating more medical school seats by expanding existing programs and establishing new medical schools are more costly to implement, enacting more systemic changes such as updating the medical school curriculum to reflect the challenges of serving diverse patients will go a long way in creating an atmosphere that is accepting and cognizant of diversity.

These academic efforts should be coupled with changes to the admissions criteria that take into account the kind of physician workforce that California will increasingly need: physicians that will work in minority communities and that possess sufficient cultural and linguistic competence to do their work effectively.

Given the strong propensity for minority doctors to work with California's poor, uninsured, and rural patients, any effort by the University of California that results in increasing diversity in the medical schools will be a great contribution to the welfare of all Californians.

This report shows that improvements have already been underway, but only bold leaps forward and strong leadership behind the issue of diversity will achieve the results necessary to move the demographics of the UC medical schools closer to the demographics of the state as a whole.

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24. Author's calculations from American Association of Medical Colleges (AAMC) Medical Student Diversity data provided to Greenlining.

25. Author's calculations from California DOF demographic data. See *supra* note 1.

26. Author's projections from AAMC data. See *supra* note 24.

27. Author's calculations from Medical Board of California Physician Survey data, 2001.

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