

Expanding the Role of Student Affairs Practice in Medical Institutions to Include Minority Student Recruitment

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Introduction

The question of access to higher education for students from underrepresented populations frequently appears at the top of debated issue lists. Access issues range from policy formation at the college and university level or in the federal government sector, to the development of recruitment and admission projects such as educational opportunity programs. Although rarely explored, access issues underrepresented minorities (URM's) face in graduate and professional medical institutions providing degrees in dentistry and medicine emerge as issues of particular interest. As defined by the Association of American Medical Colleges, underrepresented minorities in medicine include blacks, Mexican Americans, mainland Puerto Ricans, and Native American Indians, Alaskans and Hawaiians (Terrell & Beaudreau, 2003).

This article seeks to examine why admissions tactics geared toward recruiting underrepresented minorities at medical schools have been ineffective and how moving recruitment responsibility to a position focused on diversity and inclusion within medical school student affairs offices constitutes a more effective practice. First, it outlines why current methods used by admissions offices fail to increase URM enrollment at medical schools. Further, it argues to expand certain admissions practices into student affairs units. Finally, it generates a developmental initiative for medical school student affairs units focused on minority affairs. It includes outreach in underserved communities and student mentoring programs that connect current medical students with middle and secondary school students. The article explores limitations and reasoning regarding why this approach is more effective.

Currently in medical and dental schools across the United States URM enrollment has decreased to the point where admissions offices question the balance between individual merit and societal need in their application review process (Cohen, 2003). The United States URM population exceeds 25%, and predicted to increase to 48% percent by 2050 (Ballard, 2003). However, the present demographics of medicine and dental institutions track disparately. According to Carlisle and Gardner (1998), medical schools saw a URM decrease from 1994-1996 of 5.4%. While data today suggests that there have been minimal increases (slightly over 7% from 1983 to 2007) in URM matriculation, history of enrollment projections and outcomes of medical schools

show that any increases in enrollment is followed by a decrease in admissions, showing no consistent boost in matriculation (Association of American Medical Colleges, 2004). An approach that outlines why these enrollment numbers are so low starts with the costs of medical schools. Medical institutions' tuition and fee costs range from \$23,000-\$43,000 per year. Over a four-year period, costs can total over \$122,000 depending on the school (American Association for Medical Colleges, 2009). Other added expenses students incur such as books, supplies, residency fees, tools, health insurance, and costs of living in a specific location remain excluded from this calculation.

Additional barriers responsible for low URM enrollment include the academic standards of institutions, societal constrictions, access inequalities, and interest levels of this population of students (Bergen, 2000). Of these factors, the author neglects to mention evaluating inequalities in recruitment methods and practices that medical colleges and universities utilize. Statistics pointing to decreasing enrollment numbers of URM medical students must lead to more active redevelopment of recruitment strategies in order to address this diversity gap.

Where Current Efforts Stand

The major accrediting bureaus such as the Association of American Medical Colleges (A.A.M.C.) and the American Dental Education Association (A.D.E.A.) have become major proponents in encouraging colleges and universities to increase their enrollment of URM's. For instance, the A.A.M.C. created a charge in 1991 called "3000 by 2000 Initiative." It mandated that medical schools generate a pipeline beginning at the high school level and continue throughout college and into medical school for minority students (Terrell & Beaudreau, 2003). It intended to give minority students interested in the medical field a channel of educational opportunities, predicting increased URM enrollment in medical schools. Initially, this charge lived up to expectations, creating a rise in matriculated URM's, as there was a 36.3% increase from 1991-1994 (Terrell & Beaudreau, 2003). Furthermore, this project led to the creation of an educational pipeline that included select K-12 school districts and various medical centers so that students with a potential interest in the medical profession had the opportunity to interact with current professionals and learn about the field (Cohen, Gabriel, & Terrell, 2002). However, this program existed above an undercurrent of problematic circumstances. While it created new techniques for incorporating diversity into medical schools' student populations, it did not achieve its intended numerical increases. Instead, URM numbers decreased in 1997 and fell consistently until 2000. Unfortunately, legal factors and program momentum further contributed to this decline.

A discrepancy with Project 3000 by 2000 was its length. The A.A.M.C. designed Project 3000 by 2000 to last only ten years. More thought out policies, proposals, time, and goals were needed to make the medical student population mirror the United

States' demographic makeup (Cohen, 2003). Cohen argued that ten years proved to be an insufficient amount of time for planning practices and processes to increase URM enrollment, as well as for maintaining rises in admittance. Project 3000 by 2000 demonstrated periods of erratic increases and declines in enrollment suggesting it requires more time for such initiatives to reverse any potential declines, create prominent increases, and to expand on the plan's foundation.

The last critique of this project concerns the adoption of enrollment goals at colleges and universities. Institutions, along with their Deans, must prove to politicians that affirmative action will beneficially increase the diversity of their medical student population (Wadenya, Schwartz, Lopez, & Fonseca, 2003). Because "Project 3000 by 2000" came from an outside constituency, rather than from internal college planning processes, the authors argue that undue pressures were placed on universities to reach specific enrollment numbers. While national projects can address societal concerns, benefits of diversity must prove to strengthen the strategic plans for deans and presidents of individual colleges to merit deeper embrace. Each university creates a strategic plan that guides their courses of decisions and actions. When a national plan forcibly links into a particularly local strategic initiative, it creates new external pressures on institutions for achievement. If the college's circumstances are further complicated by financial constraints, national pressures create even bigger obstacles for universities attempting to accomplish their goals. These pressures place a burden on admissions offices to hire recruiters, fund larger recruitment projects, and develop a more intricate review process (Wadenya, Schwartz, Lopez, & Fonseca, 2003). Nationally charged programs, such as Project 3000 by 2000, conflict with the balance between a college's strategic initiatives and federal government plans.

Affirmative action and the negative assumptions associated with it contribute to further decreased URM enrollment. Affirmative action policies hold a "compromise" method of admissions perspective. It relates to a Willem K.B. Hofstee theory. His formula, called a "compromise method" outlines factors taken into account and assigned weights based on specific criteria. For example "assessors are asked for the extremes of percent candidates passing and scores required to pass that would be credible" (Hofstee, 1983). What Hofstee created is a way of looking at scores (test scores, grades and other merit based categories) on a continuum for assessing balance between "maximum and minimal merit" and "maximal and minimal race quota levels" (Reiter and Maccoon, 2007). Opponents view this plan as a way for URM's to justify low merit and entry to medical school, completely divorced from qualifications evaluations. In this view, institutions accept students that lack the skill sets necessary to handling the academic rigors of medical school, yet gain an opportunity to become doctors and treat patients versus an academically qualified student (Cohen, Gabriel, & Terrell, 2002). Because of the controversy surrounding this type of policy, it remains extremely challenging to implement any method called "compromise" without raising skepticism.

In the mid 1990's various Michigan politicians came together and organized successful anti-affirmative action initiatives by compromising enrollment requirements. Similar actions in Washington and California occurred and led to decreases in URM matriculation, as morale decreased and students stopped applying to schools (Terrell & Beaudreau, 2003).

Outcomes from these initiatives reveal more turbulence than accomplishment. African-American student matriculation decreased by a total of 10% between the years of 1995-1996 (Carlisle and Gardner, 1998). Other anti-affirmative action rulings, such as *Regents of The University of California v. Bakke*, played a part in the precipitous decline of URM's medical school enrollment in the mid to late 1990's. The cases' rulings and anti-affirmative action movements created the standard for federal oversight of the affirmative action policies admissions offices establish and follow (Cohen, 2003; Reiter & Maccoon, 2007). Additionally, these actions discouraged URM's from applying to medical school, recreating a once nearly removed hurdle these populations again faced in gaining access to an education opportunity.

While Project 3000 by 2000, affirmative action polices, and older court decisions exemplify problematic enrollment initiatives for underrepresented minorities in higher education, the University of Michigan created yet another approach that brought other burdens of heavy legal review. A student applied to the University of Michigan's Law school in 1996, only to be denied admittance, even with a 3.8 GPA and a 161 LSAT Score (Carcieri, 2004). The student brought a discrimination suit against the college after investigating that applicants of black and other minority backgrounds with lower scores were admitted (Carcieri, 2004). The final outcome of the case found the Supreme Court rendering a decision that Michigan: "having expressly declared its use of race preferences, could show no pattern of identified discrimination" (Carcieri, 2004). The court chose to allow the use of race as one of multiple factors for consideration of admission to the university (Carcieri, 2004).

While a step in the right direction, Carcieri (2004) argues that, the issue approaches a level of constitutional support. The author states that because the courts "permit" rather than "require" the use of race in admissions criteria, Michigan as well as every other state may reject using these techniques (Carcieri, 2004). With no law in place, college officials choose how they will recruit and enroll students. For URM's looking to enter into the fields of medicine and/or dentistry, their eligibility is compromised, as college administrators hold no compelling interest in the importance of diversity. With no driving force, the Michigan decision, deemed a landmark ruling in affirmative action progress, truly denies minority students the chance to attend medical school purely in the college official's discretionary interest.

Expanding the Role of Medical School Student Affairs Units

These enrollment challenges demand a new approach to achieve higher enrollment numbers of URM populations at institutions and medical schools across the country. New student affairs research reaches beyond the typical undergraduate institution services and not only suggests but justifies its purpose for existence in graduate and professional schools. Woodward and Komives (2003), and McGuire and Phye (2006) state that it has become extremely important for graduate students, as well as the related service offices, to become part of the developmental programs and initiatives around which undergraduate student affairs offices pride themselves. These programs include leadership skill-building workshops, advisement, and experiential learning opportunities.

While the aforementioned programs are more commonly found in undergraduate schools, and less commonly in student affairs units at a medical institution, new thinking suggests extending services beyond what is already provided to include more innovative practices. Recruitment and enrollment functions are often thought as reflective of admissions offices only. However, with limited flexibility in services by admissions offices and the push from AAMC and ADEA for colleges to become proactive in minority recruitment, student affairs units become a suitable choice for assuming this role. Ballard (2003) believes that if medical schools undertake the thinking that AAMC developed in 1975 regarding the creation of a minority affairs section within the organization, planning between higher education and larger associations becomes more collaborative. The inclusion of student affairs offices within this structure brings this concept to life.

To begin, positioning this function in student affairs creates several opportunities, especially as medical admissions offices focused on applications processing and review, in addition to the interview process consumes enormous amounts of capacity. As the admissions work increases, recruitment diminishes (Reiter and Maccoon, 2007). Therefore, it is beneficial to assign this recruitment role to middle and lower management in student affairs, versus assigning it to an assistant dean, associate dean, vice president, or director, as the responsibility is too specific for the higher management level (Ballard, 2003). The primary responsibilities consist of various types of URM recruitment. This position is accountable for building educational recruitment programs for secondary students. These types of programs will be introduced and presented to students enrolled in secondary schools with high URM populations. They focus on educational awareness, mentoring using current third and fourth year URM medical students, and involve various hands-on workshops. For example, in 1985 New York State funded eleven medical schools to create Science and Technology Entry Programs (S.T.E.P.) (Jones and Flowers, 1990). With S.T.E.P.,

students connected with minority medical students, learned about the various fields of medicine, and gained an early educational experience.

While most student affairs offices cannot fund programs as expansive as S.T.E.P., the idea of developing programs that create awareness of the medical field and spike interest in students at an early age remains salient. Additional aspects include establishing mentor and ambassador programs using URM medical students. These students go out to the middle and high schools with the student affairs representative. Their responsibilities include developing relationships with the secondary students, tutoring them in their studies, exposing them to the medical field, and discussing personal stories in order to create a personal bond. Housing this position in medical school student affairs units creates the beneficial opportunity to encourage minority medical students to open chapters of nationally accredited cultural associations at the institution. For example, with the help from the administrator occupying this new position in the Student Affairs Department, that person will identify minority associations, such as the “Hispanic Student Dental Association” or “The Student National Medical Association,” and assist students with the creation of a chapter.

The responsibilities outlined above are some of the student affairs-related tasks that constitute this position. Through external outreach and educational awareness efforts towards underprivileged school districts with high URM populations, this position develops a pipeline between secondary schools and medical institutions (Jones and Flowers, 1990). This pipeline attracts and channels minority students to the medical field and provides educational opportunities for them to expand their knowledge before they even reach the college level. Echoing the original goal of Project 3000 by 2000, “A core strategy of the project focused on creating small-scale educational reforms through durable, minority-focused community partnerships between academic medical centers, such as a college or university, and selected K-12 school systems and potential pipeline colleges” (Cohen, Gabriel, & Terrell, 2002, p. 97). While there was participation from various foundations such as the Robert Wood Johnson Foundation, it did not create a direct relationship between medical school representatives and the secondary school students.

By creating a position in student affairs geared toward minority development, a school forges an interpersonal relationship with the young students, in addition to creating resources for them. Institutions such as University of Pennsylvania’s School of Dental Medicine created a mentoring program and a “Bio-Dental Consortium” for high school seniors that introduced various science subjects and dental techniques to these students (Wadenya, Schwartz, Lopez, & Fonseca, 2003). This school alone claims that their URM enrollment has increased fivefold within the 13 year time span since the implementation of various programs (Wadenya, Schwartz, Lopez, & Fonseca, 2003). Another example of this outreach comes from Baylor College of Medicine and their

efforts with the surrounding schools in Houston to rebuild curriculums and develop outreach programs to pique aspirations in medical school for high school students (Mangan, 1997). In collaboration with Rice University, Baylor conducts a six-week summer program for minority high school students who are interested in a career in medicine. Aside from students, physicians also partake in the outreach, as they too want to make a personal effort in recruiting URM's. Because of this program, Baylor's first year enrollment of minority students in their medical program doubled, where URM's make up 23% of their class (Mangan, 1997).

Limitations Facing the Shift in Practice

It is important to note that while the basis of this shift in practice stems from a combination of ideas from previous projects, limitations in practice must be identified. Ballard (2003) outlines a specific concern that pertains to the creation of an office or position focused on minority recruitment efforts within student affairs. This aforementioned concern assumes that special services and programs are developed for a designated group, rather than the educational student population. From his perspective, this limits programming toward only minority students and thus creating an educational discrimination factor. As stated earlier, if the administrators who create the strategic plan believe that creating these programs is not enhancing diversity but prompting discrimination towards applicants, the likelihood of its approval is unlikely (Wadenya, Schwartz, Lopez, & Fonseca, 2003). Demographic location of a medical institution constitutes a second limitation. If an institution is within a close proximity of school districts or heavily populated URM neighborhoods, outreach efforts and student involvement will be simple to formulate. Universities that are not geographically located within close range of a school district makes URM medical student involvement much more challenging. Anderson, et al (2009) interviewed URM students who applied to Boston University and University of the Pacific and found that the geographic location of underserved "feeder schools" (high schools and colleges) not within their surrounding community make it more challenging for them to move (p. S.244). At the same time, URM's may find they have a strong connection to their family environment and thus will not want to move away from their family to attend school (Anderson et al., 2009). Bergen (2000) identifies a third limitation, stating that many administrators who make up a medical school believe that the underrepresentation of minorities in the medical field is not a result of a lack of recruitment, but rather an "underlying racial barrier within U.S. society" (p. 1139). He later adds that that medical and dental administrators use this argument to absolve the institution from the social context faults that plague our society, exempting them from having to make necessary changes to their institutional structure. This deficit-minded argument is used to sway a university's involvement away from a plan like "Project 3000 by 2000," and to focus on the population they already have.

Conclusion

Despite the challenges that the creation of this position may face, the integration of minority student development and outreach within medical school student affairs offices remains crucial to increasing the URM enrollment in medical schools. With the decrease in minority physicians and dentists in the United States emerging as a growing issue, medical institutions continue to search for ways to create the most effective practices for reversing this trend. By taking components from Project 3000 by 2000 and using the idea that Komives and Woodward propose regarding additional roles for Student Affairs units, (such as the development of a position in Student Affairs focused on minority development,) recruitment and outreach give secondary school students direct access to educational opportunities within the medical field.

Within the institutions themselves, the Student Affairs position creates opportunities for current medical students to participate in community outreach and inspire young URM's to consider pursuing careers in medicine. This complements the notion of developing students holistically, as it give students professional and community development components in graduate school. In all likelihood, this will raise awareness and create managed channels of opportunities for schools, communities, students and future practitioners. Steep challenges to creating this diversity focused student affairs position persist as institutions must contend with strategic plans, geographical barriers, and deficit-minded thinkers. With a strong push from Student Affairs administrators, institutions will benefit from a more diverse student body and simultaneously, create the chance for underrepresented student populations to engage in medical careers.

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