Project 3000 by 2000: Expanding Our Network

By Herbert Nickens, MD, MA, and Timothy Ready, PhD

Closing the Gap, Putting the Right People in the Right Places • May/June 1999

Just 35 years ago, U.S. medical schools were as racially segregated as most other institutions in American society. Ninety-seven percent of medical students were non-Hispanic Whites. As recently as 1964, only 2.2 percent of the 32,000 students enrolled in the nation's existing 83 allopathic medical schools were Black. The two Black medical schools, Howard and Meharry, enrolled three-quarters of these students.

This meant that on average, each of the other 81 schools enrolled only one Black student every other year. In 1971, the first year for which there are data on minority groups other than Blacks, only 19 Mexican American, 14 mainland Puerto Rican, and 2 American Indian physicians graduated from U.S. medical schools.

Moving toward diversity

In the 1960s we agitated for civil rights, and there were urban riots. But it was Martin Luther King's assassination that was the catalytic event that led to greater racial/ethnic diversity in medical schools. At the 1968 annual meeting of the Association of American Medical College (AAMC), medical students, faculty members, and administrators successfully pressed for the creation of a task force to set goals for minority enrollment and recommend strategies to achieve those goals.

Private foundations and the federal government provided broad support for programs directed at increasing the number of minorities in medicine. Enrollment of minority medical students increased from approximately 3 percent of new entrants in 1968 to almost 10 percent in 1974.

As minority enrollment rose in the early 1970s, a backlash occurred not unlike the one we are experiencing now. There were charges of reverse discrimination and lawsuits that had a chilling effect, such as the De Funis and Bakke cases. Though it is difficult to prove cause and effect in these matters, we do not believe that it was a coincidence that minority enrollment in medical schools leveled off in the mid-1970s at about nine percent. There it remained until we began organizing Project 3000 by 2000.

The name Project 3000 by 2000 derives from our goal: to enroll 3,000 underrepresented minorities annually in U.S. allopathic medical schools by the year 2000. Underrepresented minorities by AAMC's definition are Blacks, Mexican Americans, mainland Puerto Ricans, and American Indians and Alaska Natives.

Achieving our enrollment goal would mean that we had reached approximate population parity for underrepresented minorities, those racial/ethnic groups that had historically been denied economic and educational opportunities. This goal is not new, but it has been embraced by the AAMC since 1970. Our intention was to energize people around this initiative and emphasize the need for accountability.

Getting to the root of the problem

We set about analyzing past strategies to determine why they had not been more successful. Our conclusion: The programs put in place in the late 1960s and 1970s, while helpful and necessary, were insufficient to address the primary problem. That problem is the failure of our nation's K-12 schools and our colleges to produce a sufficient number of academically well-prepared minority students.

Data from the U.S. Department of Education's National Assessment of Education Progress (NAEP) starkly demonstrate this problem. NAEP measures the academic skills of our young people at several ages and in various subject areas. The data aren't pretty.

There are substantial racial/ethnic gaps in average scores. Even more alarming are the disparities in the percentage of Black, Hispanic, and White students who demonstrate advanced academic skills. This is especially troubling because these are our future physicians, dentists, and other health professionals.

One can estimate the number of students from various racial/ethnic groups with high-level academic skills by examining the percentage of 17-year-olds who score 350 or higher on the NAEP science exam—13 percent of Whites, 1 percent of Blacks and 2 percent of Hispanics. Data are not available for American Indians.

By multiplying these percentages by the number of 17-year-olds in each of those groups, we estimate that there are about 334,000 White 17-year-olds with advanced skills in the sciences, compared to only about 3,500 Blacks and 4,500 Hispanics. And it gets worse.

Because students who do well in science also tend to do well in other subjects, these numbers not only give us some fix on the small pool of high school students who are ready to pursue science-based careers, it also reflects the small number of students who have the level of academic skills needed to succeed in law and business schools or earn doctoral degrees in liberal arts and social sciences.

As we grappled with troubling statistics such as these, we concluded that any socially responsible and effective new program intended to increase minority enrollment in medical schools must address these fundamental academic shortfalls.

Launching Project 3000 by 2000

The underlying premise of Project 3000 by 2000 is that we must increase the number of students who are both interested in medicine and academically prepared for medical school. We also believe that massive new resources are not necessarily required to address this problem. What is required are leadership, vision, and a willingness for educational institutions and community organizations to collaborate.

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We must ensure that many more minority students are exposed to school, home, and neighborhood environments in which high academic achievement and high career aspirations are valued and expected. We must nurture interest in health careers and monitor the academic performance of both students and educators.

We launched Project 3000 by 2000 in 1991 with a series of workshops for medical school deans. Starting with the deans was essential because the Project's success depended on setting institutional priorities, and on the ability of medical schools to secure similar commitments from leaders at partner institutions.

Despite the fact that the medical schools had no external funding to implement the project, all of our deans signed on. Within a few months, virtually every medical school had appointed a Project 3000 by 2000 coordinator. During the early years of the Project, the number of underrepresented minority matriculants increased from approximately 1,500 to more than 2,000, in part aided by an overall increase in the applicant pool. Although these early gains were not directly attributable to the new initiatives launched under the auspices of Project 3000 by 2000, they almost certainly are attributable, at least in part, to the high visibility given to the cause of diversity in medicine.

As the number of Project 3000 by 2000 initiatives targeting middle and high school students grew, it soon became apparent that these youngsters needed to be exposed to a wider array of health professions. We also realized that all of the health professions essentially draw from the same pool of high achieving students.

As a result, we began to collaborate with national organizations representing dentistry, nursing, osteopathic medicine, and others, and urged them to "buy in" to the Project 3000 by 2000 "pipeline" model. In 1994, the Robert Wood Johnson Foundation provided funding to support a "multi-health professions" grants program called the Project 3000 by 2000 Health Professions Partnership Initiative (HPPI).

And in 1996, the W.K. Kellogg Foundation joined in supporting the HPPI. When grants from the third funding cycle of the HPPI are awarded in February of 2000, we expect that there will be 26 funded HPPI partnerships across the country.

Up against the backlash

We are often asked, "Will you reach 3,000 by the year 2000?" The short answer is "No." We will not reach our matriculant goal of 3,000. As happened 20 years before, we are now witnessing a backlash against initiatives designed to enhance racial and ethnic diversity in higher education and in the professions. Court cases with new names like Hopwood and Aadarand, and in a new wrinkle, Proposition 209 and Initiative 200, stir up resentment with accusations of reverse discrimination.

Yet America's fundamental challenge of persistent racial disadvantage and inequality, so eloquently described 55 years ago by sociologist Gunnar Myrdal in the classic, An American Dilemma, persists as we enter the new millennium. Although much has changed in America, we are nowhere near eliminating the gaping racial disparities in health and education that have plagued our nation.

It is these disparities that Project 3000 by 2000 programs will continue to address. Besides contributing to the substantial gains in underrepresented minority enrollment in medical schools that occurred during the 1990s, Project 3000 by 2000 has created a foundation for long-term progress by:

1. Contributing to the growth of the "pipeline model." We have promoted this model as a way to address the academic needs of students as they progress from pre-college years into baccalaureate and postgraduate health profession schools.

2. Producing a significant body of published work. We have been able to document and analyze some of the tough issues related to the problems of minority academic achievement.

3. Creating sustainable partnerships. We have forged partnerships that we believe are sustainable among K-12 school systems, colleges, health profession schools, and community-based organizations, entities that have not collaborated in the past, but in the interest of our children, must collaborate in the future.

Dr. Nickens is the late Vice President and Dr. Ready is Assistant Vice President of the Division of Community and Minority Programs, Association of American Medical Colleges. ❖