Statement on

Black Men in Medicine

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Statement on
Black Men in Medicine
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Introduction

Black/African Americans currently make up 13.4%, roughly 44.8 million, of the total United States (US) population. Within the 13.4%, Black/African American men currently make up 48% or an estimated 21.5 million total people. As the Black/African American population continues to grow, one would assume that the rising percentages would also correlate to the field of medicine. However, a recent University of California, Los Angeles (UCLA) study finds that the opposite has occurred. In 1940, Black/African American men made up 2.7% of the Black physician workforce and Black/African American women 0.1%. Fast forward to 2018 where Black/African American men made up 2.6% percent of physicians and 2.8% were Black/African American women. Based on data analyzed by the US Census Bureau, this represents an alarming 0.1% decrease from the 1900s. Particularly, an increase from 9.7% to 12.7% in Black/African U.S. population growth can be seen from 1940 to 2018; yet, the medical professional percentages remain stagnant. Furthermore, fewer Black/African American men are currently applying, enrolling, and matriculating into medical school. While Black/African American male medical students accounted for 3.1% of the national medical student body in 1978, in 2019 they accounted for just 2.9%. This continuous decline can be attributed to multiple factors including lack of opportunity, adverse childhood experiences, scarcity of resources and mentorship, systemic racism, and the overall expense of becoming a physician. As the gap between the number of African American males in this country and the number of African American male physicians continues to widen, it is evident that action must be taken to mitigate any further damage to our healthcare system. With a population that continues to diversify and a declining percentage of Black/African American male physicians, patients are increasingly unable to relate to their providers which contributes to biased medical practices and inequitable healthcare. Thus, the purpose of this statement is to highlight the history and current shortage of Black/African Americans in medicine, the detrimental effects this shortage has on health and health outcomes for patients of color, and the urgent need for targeted efforts to eliminate this shortage.

Background

Focusing on the underrepresentation of Black/African American men in medicine is central to the SNMA mission of supporting students underrepresented in medicine (URiM) and addressing the needs of underserved communities. The shortage of Black/African American men as healthcare providers, professors, clinical researchers, and medical students negatively impacts the quality of care of Black, Indigenous, and people of color (BIPOC) populations. This lack of representation subsequently leads to poorer health outcomes for Black/African American males in comparison to their White counterparts. Black/African American men in the US continue to suffer worse health outcomes in comparison to all other major demographics in the United States. On average, black men die more than 7 years earlier than US women of all races, and black men die younger than all other groups of men, except Native Americans. This disparity
can be attributed to age- and cause-specific morbidity and mortality, lesser insurance coverage, incarceration, unemployment, and decreased access to adequate healthcare. The top five leading causes of mortality for Black/African American males are heart disease (24%), cancer (20%), Alzheimer’s disease (8%), stroke (4.5%) and homicide (5%), respectively. Respiratory disease, obesity, diabetes, kidney disease, and hypertension also contribute to increased morbidity and mortality in Black/African American men. Most of these causes are preventable chronic illnesses with effective treatment options, therefore healthcare access and point of care should be prioritized.

The historical mistreatment and neglect of Black/African American males has inevitably reduced the trust that Black/African American males have in providers and the healthcare system at large. This trust was broken by generations of unethical medical experimentation and denial of pain exemplified by the Tuskegee Study of Untreated Syphilis. Increasing the number of Black/African American men in medicine will help rectify this distrust in healthcare and medical professionals. Having a race-concordant medical provider can lead to better patient care outcomes. Therefore, having Black/African American male physicians who are available to provide care for Black/African American male patients will improve the health outcomes of this population. The presence of Black/African American male physicians at the patient’s bedside is important and the current representation of less than 3% is inadequate.

The absence of Black/African American physician leaders in the academic space leaves opportunities for missed mentorship for Black/African American male medical students. Thus, this problem perpetuates itself, making it difficult for Black/African American applicants to pursue and thrive in medical careers. The lack of Black/African American male representation in medicine has deep historical roots, as Black/African American men have been ostracized from the medical field for many years. For example, the 1910 Flexner Report led to the demise of five of seven academic institutions providing medical education to Black/African American males during that time. The strategically formed standardized criterion forced medical school closings leaving only Howard University College of Medicine and Meharry Medical College, the founding institutions of the Student National Medical Association, Inc., responsible for training Black/African American physicians. Extrapolated data indicates that the closing of Flint Medical College, Knoxville Medical College, Leonard Medical School, Louisville National Medical College, and University of West Tennessee can be directly linked to the racial gap of healthcare providers as it inaccurately reflects the population. Data shows that as of 2019, more than thirty-five thousand students would have matriculated and graduated through these HBCU programs alone and thus thirty-five thousand Black/African American physicians would have been available to provide care. According to the AAMC, the 2022-2023 academic year was the first year Black male matriculants increased by 5%. Therefore, it can be noted how historical context has contributed to the stagnation of Black men in medicine and efforts must be made to
continue the increase in Black male medical school matriculants and ultimately Black male physicians.

Scope

The gap in health equity between Black/African American people and White people in the US is staggering and, as the nation’s diversity increases, so do the rates of health disparities. Black/African American men have the highest mortality rate and lowest life expectancy in the United States when compared to other ethnic and gender groups. As previously mentioned, a significant factor contributing to preventable deaths among Black/African American men in the US is medical mistrust in the healthcare system. Medical experimentation on Black/African American men, such as in the Tuskegee Study of Untreated Syphilis in the Negro Male, has contributed to a pattern of lower healthcare utilization and higher mortality for many generations of individuals who identified with those victims. Mistrust in the healthcare system is higher in Black/African Americans compared to other racial groups and is associated with negative outcomes such as decreased satisfaction with healthcare and lower treatment adherence and utilization of health services. Lack of healthcare utilization coupled with the dwindling number of Black/African American male professionals in medicine has likely exacerbated these public health issues. Furthermore, many of these negative health outcomes are ameliorated when patients are race-concordant with their physician. Patient satisfaction with care was also linked to higher utilization of healthcare services, compliance with a health-promoting regimen, and several other factors. Further, research shows significantly more URiM physicians choose to work in historically underserved areas, which are often predominantly comprised of minorities, and care for uninsured or Medicaid patients versus their non-minority counterparts. This is significant because it suggests that increasing Black/African American physicians could help increase access to care for many of these communities.

Countless studies denote the importance of diversifying medicine to address health disparities and develop cultural humility among physicians. Unfortunately, the rate of increase in the number of Black/African American male physicians has decreased over time. In fact, there has been a paradoxical trend in which the number of Black/African American men matriculating into medical school has decreased. Only 37.8% of Black/African American applicants to medical school were men in 2014. Moreover, a 2017 study found Black/African American men are less likely to reapply after not being accepted into medical school. These alarming statistics in part account for why Black/African American men are only 3% of the physician workforce.

While many medical institutions have acknowledged the lack of diversity in the medical field, there is much debate about the best ways to address the problem. The American Association of Medical Colleges (AAMC) created one of the largest diversity initiatives to date: Project 3000 by 2000, which was a program to increase the total number of URiM medical
students to 3,000 by the year 2000. While this initiative was a great start, there are a multitude of other systemic barriers that bar access to pursuing a career in the medical field for Black/African American men, including financial cost, systemic discouragement of Black/African American men entering medicine, bias and stereotypes, and lack of pre-medical resources. To achieve health equity, the SNMA maintains that more must be done at every level to increase accessibility to the medical profession for Black men.

Statement of Position & Recommendations

The present lack of Black/African American male physicians stems from a long-standing history of targeted oppression and systemic racism in the US. Instead of the numbers of Black/African American men in medicine mirroring the increase in diversity of the US population, there has been an overall decline in the number of Black/African American males who matriculate to and graduate from medical school. The COVID-19 pandemic has further exacerbated health inequities in the Black/African American community. Health outcomes may improve with the recruitment of a physician workforce that is more representative of the US population.

The SNMA proposes several strategies to increase enrollment of Black/African American males in medical school. Dr. James L. Moore, III, Executive Director of the Bell National Resource Center on the African American Male at the Ohio State University, has researched and identified the following factors that influence career development for Black/African American men: “interests, preparation, experiences, connections, and opportunity.” Black/African American men should be exposed to medicine as a career option early, so initial interest is established at a young age.

Pipeline programs, that target Kindergarten to twelfth grade education and continue throughout undergraduate and eventually medical school, play a key role in early exposure to the field of medicine. SNMA currently facilitates the Youth Science Enrichment Program (YSEP) throughout the country, where medical students teach a structured science curriculum to local elementary and middle school students. Black Men in White Coats has youth summits that address the cardiovascular disparities that disproportionately affect Black/African American communities, through hands-on events for students and programming for parents. The Health Professions Recruitment and Exposure Program (HPREP) and the I Am Abel Foundation are two other pipeline programs that serve to increase URiM exposure to medicine. Increasing partnerships between local schools allows medical students to form relationships with the communities where they receive medical training. These relationships can also empower young learners to pursue a career in medicine through the attainment of science, technology, engineering, and mathematics (STEM) knowledge and through positive interactions with student doctors who look like them. Expanded financial support of pipeline programs like these, will increase Black/African American male exposure to STEM fields and mentors with similar backgrounds. These programs have proven to be effective in increasing diverse representation in
healthcare fields and could potentially reduce the discouragement of Black men from pursuing medical careers by their communities. It is also imperative to fix identifiable gaps in the medical school pipeline programs that occur early in career development. Ultimately, we must invest more money and resources into both high school and undergraduate bridge programs.

Additionally, Historically Black Colleges and Universities (HBCUs) have been at the forefront of producing Black/African American applicants that go on to attend medical school. These efforts should be highlighted with amplified financial support from these institutions of higher learning that have cultivated spaces that encourage more Black/African American students to pursue careers in medicine. Additionally, applying to medical school requires pertinent academic advising, access to standardized testing resources, and finances to cover the expense of applications and interviewing. While the AAMC has a fee assistance program to help reduce medical school application costs, there must be additional funding options provided to help reduce other financial burdens associated with applying to medical school, such as funding for attending interviews, second look activities, and moving expenses. Additionally, exploring ways to provide reduced or free tuition to Black/African American men would further decrease the financial burden.

Black/African American men require strategic mentoring that is tailored to their specific needs to help facilitate the navigation of the medical school application process. Mentored support, including cross-cultural interactions, should address cultural mistrust and directly engage in conversations on race. Furthermore, financial aid programs that provide monetary grants to cover MCAT registration fees and medical school application fees should consider funding costs for Black/African American male students across all socioeconomic statuses.

Expanding affordable preparatory programs and counseling unsuccessful applicants could help reduce the previously mentioned disparity in Black/African American male reapplicants. Having a supportive network is correlated with the success of Black/African American men in medicine. Furthermore, social support has been shown to be critical for academic success, navigating adverse events, and developing resiliency to persevere through the rather arduous process of becoming a doctor.

Further recommendations include expanding the sizes of medical school classes to ensure greater representation of Black/African American males and diversifying admissions committees through increased hiring of Black/African American medical faculty. Additionally, reviewing medical school applications through a more holistic approach is essential. Reviewing applications more holistically will allow for the acknowledgment of the variety of experiences, skill sets acquired, and challenges faced by students that will prepare them for their future roles as physicians. Equally evaluating intangible qualities and diverse life experiences will make the application process more inclusive and go beyond a pure focus on MCAT scores and grade point averages. A more equitable healthcare landscape can be established by cultivating the creation of a more diverse medical field which includes the adequate representation of Black/African American males.
References


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