Commentaries

Medical Schools, Affirmative Action, and the Neglected Role of Social Class

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A B S T R A C T

Medical schools' affirmative action policies traditionally focus on race and give relatively little consideration to applicants' socioeconomic status or "social class." However, recent challenges to affirmative action have raised the prospect of using social class, instead of race, as the basis for preferential admissions decisions in an effort to maintain or increase student diversity.

This article reviews the evidence for class-based affirmative action in medicine and concludes that it might be an effective supplement to, rather than a replacement for, race-based affirmative action. The authors consider the research literature on (1) medical students' socioeconomic background, (2) the impact of social class on medical treatment and physician–patient communication, and (3) correlations between physicians' socioeconomic origins and their service patterns to the disadvantaged. They also reference sociological literature on distinctions between race and class and Americans' discomfort with "social class." (*Am J Public Health.* 2000;90: 1197–1201)

Medical school admissions policies involve a paradox regarding student diversity. On the one hand, medical school administrators have launched campaigns to recruit more ethnic minority medical students.[1] A key motivation has been the growing evidence that minority physicians disproportionately serve poor and ethnic minority communities.[2–8] On the other hand, admissions committees assign relatively little weight to applicants' socioeconomic status (SES) or "social class."[9] In effect, they stress racial diversity but downplay socioeconomic diversity.

Policy research on the medical education system has demonstrated a similar focus on race over social class. Although a variety of studies highlight the benefits of increased racial diversity among physicians, there has been limited research, especially in the United States, and especially during the past 2 decades, on physicians' socioeconomic background and its influence on their practice or service patterns.

Because class and race are imperfectly correlated and index distinct (although overlapping) attributes,[10–15] we believe that both deserve attention in medical school admissions decisions. Accordingly, we argue for an expansion of affirmative action to include social class as a supplement to race. Considerations of individual justice favor a review of medical school applicants' SES. Moreover, there is a possibly compelling public policy justification for evaluating class; there may be a need for more physicians from lower-SES backgrounds, just as there is a widely recognized need for more minority physicians. A similar logic applies: we hypothesize that recruiting more physicians from less advantaged backgrounds would improve access to health care because a disproportionate percentage of such physicians would establish practices in their home communities.

Whether or not one agrees with this reasoning, an inattention to social class in medical school admissions decisions may no longer be feasible. Recent challenges to affirmative action (see Hochschild[16] and Bowen and Bok[17]) have had the surprising effect of placing social class at the center of policy discussions about postsecondary education, including medical education. Conservative[18,19] and liberal[11–13] commentators alike have advocated using SES or social class—instead of race—as the basis for preferential recruitment and admissions decisions.

Proponents of this approach argue that racial preferences, originally intended to compensate for *past* discrimination against ethnic minority groups,[11–13] have perpetuated rather than resolved social inequities.[19] Such preferences may even benefit economically privileged individuals who belong to ethnic minority groups. By contrast, they hold that it is fair to consider SES because (1) socioeconomic disadvantage is a *present* handicap, not an intergenerational one, and (2) socioeconomic disadvantage can be assessed at the level of the individual candidate, not just in the aggregate. Detractors of this argument have expressed alarm over a potential disruption to gains in ethnic minority enrollments. However, even they agree that class-based affirmative action may be appropriate, providing it does not replace race-based affirmative action, which they claim is necessary to ensure racial diversity.[14,17]

Medical schools can ill afford to disregard this debate and may be especially vulnerable to lawsuits over their racially based affirmative action policies. According to Helms

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and Helms, "Cases involving professional schools have been at the leading edge of affirmative action litigation…, in part because the incentives for medical students to resort to litigation in terms of projected benefits are high."[20(p231)] Barzansky et al. note that medical schools, prompted by legislative and court challenges to affirmative action, have reexamined their recruitment and admissions policies regarding race.[21–23] They speculate that this reexamination may have contributed to declining ethnic minority enrollments.

In the remainder of this article, we consider the evidence for class-based affirmative action in medicine. The central question is the following: Should medical school admissions committees weigh applicants' socioeconomic origins more explicitly and heavily? To answer this question, we review the published research literature on (1) medical students' socioeconomic background, (2) the impact of social class on medical treatment and physician–patient communication, and (3) correlations between physicians' socioeconomic origins and their patterns of service.

Socioeconomic Background of Medical Students

According to medical historians,[24,25] the practice of recruiting US physicians primarily from the middle and upper classes is a relatively recent phenomenon corresponding to Abraham Flexner's famous 1910 report, *Medical Education in the United States and Canada*.[26] The report's recommendations led to standardized training programs, increased their scientific orientation, and transformed medicine from an apprenticeship system into a university discipline. The reforms closed down many "lower-tier" medical schools that had enrolled disproportionate numbers of lower-SES, ethnic minority, and female students. Opportunities for such students to obtain a medical education diminished.

Many commentators[27,28] believe that the mixed legacy of the Flexner report—higher medical standards but more limited access to medical education and medical care—continues to this day. Although caution must be exercised in generalizing from the experiences of 1910 to the present, lessons can be learned from the historical record and might guide renewed research.

Studies from the 1970s and early 1980s corroborate the nonrepresentative social origins of medical students, but this research needs updating. Boerner and Thomae-Forgues found that White medical school applicants and accepted students were concentrated in higher-income families.[29] Likewise, Becker et al. observed that "[m]edical students tend to be recruited from the higher socioeconomic groups in our society" and often belong to medical families.[30(p192)]

There is evidence from Canada[31] and Britain[32–35] that, although medical school admissions committees do not actively discriminate against lower-SES applicants, applicants in general are an affluent and privileged group. Consequently, the social composition of the medical student body simply reflects that of the applicant pool. These studies imply that medical schools should focus on recruitment, not admissions, in order to increase their students' socioeconomic diversity. However, if recruitment efforts fail to broaden applicant diversity because of barriers such as the expense and length of medical training,[35] admissions committees may need to weigh SES more heavily. Indeed, applying the affirmative action model would imply a 2-pronged strategy: reforming *both* recruitment and admissions.[17,36–38]

Has access to medical education diminished for lower-SES students? We know of no research on this subject, but growing debt levels among medical students suggest that medical education has become less affordable.[39] Also, consider the high cost of undergraduate premedical training. Because medical schools exist within a broader educational system, they must screen applicants on the basis of their undergraduate performance and are not immune to general trends in postsecondary education. Takagi suggests that access to postsecondary education has declined for disadvantaged students, in part as a result of "more stringent federal criteria for determining who is 'financially independent' and thus eligible for more aid."[14(pA52)] Some colleges and universities have charged that need-based financial aid is "under attack."[40] According to Ballantine, higher admissions requirements and expectations have also led some universities to recruit students from wealthier geographic areas.[41]

If, as we hypothesize, medical schools have conformed to these general trends, the socioeconomic origins of medical students may have become *less* representative. At least it is likely that downplaying social class in admissions decisions results in the continued enrollment of medical students principally from the middle and upper classes. To inform policy and planning, more research is needed on the socioeconomic and demographic backgrounds of medical students.

Social Class and the Doctor–Patient Relationship

It has long been recognized that patients of lower SES receive inferior medical care and have more limited access to care than higher-SES patients.[42–52] Inequities in medical insurance[53] and lower-SES patients' constrained financial resources contribute to this problem. However, social class differences between physician and patient play a documented role as well. They are implicated in difficulties of communication[54–56] and in lower-SES patients' inferior psychiatric treatment.[57] Murray passionately argues for the recruitment of more working-class physicians in Britain in order to improve the psychiatric and general medical care of disadvantaged patients.[33] There is also evidence from the United States and abroad that class differences influence a doctor's acceptance of a person as a patient, especially in the case of psychotherapy.[54–61]

Communication appears to suffer when physicians treat disadvantaged patients. According to Dungal, physicians report more anxiety and frustration, and less interest and comfort, following interviews with lower-SES patients.[62] Waitzkin finds that better educated and higher-SES patients receive more information from physicians, even though lower-SES patients desire the same amount of information.[63] Taira et al. observe that physicians are less likely to discuss diet and exercise with lower-income patients but are more likely to discuss smoking.[64] The irony is that lower-SES patients seem to place a special emphasis on interpersonal interaction with their physicians. According to Wolinsky and Steiber, persons of lower SES and with poorer access to medical care rate the psychosocial aspect of the patient–physician relationship as the most important criterion in selecting a physician.[65] These findings highlight the need for sensitive communication with lower-SES patients.

Differences in styles of communication may be especially problematic in psychiatry. According to Bernstein, psychotherapy involves speech systems tailored to the middle and upper classes.[66] Perhaps as a result, there is evidence of social class bias in psychiatric treatment.[61] Both Kurtz et al.[60,] and Stein et al.[67] report that psychiatrists prefer to treat middle-class instead of lower-class patients and assign them more optimistic prognoses. Barney et al. find that hospital workers treat middle-class psychiatric patients more favorably than lower-class patients.[55] According to Umbenhauer and DeWitte, mental health professionals seem "more aware of or sensitized to black-white discrimination than to social class discrimination,"[57(p514)] and "[s]ocial-class bias may be an outgrowth of class and cultural differences [between clinician and patient]."[57(p513)]

Clearly, such problems of communication and bias can be resolved only by increasing sensitivity among *all* physicians. However, recruiting more medical students from lower-SES origins might help raise awareness through the socialization process

that occurs during medical school.[1,17,68–73] Moreover, research findings suggest, albeit tentatively, that physicians from lower socioeconomic strata might be better equipped to care for patients from similar backgrounds. Consider that (1) physicians are nonrepresentative of the overall population in their socioeconomic origins, (2) patients from lower-SES backgrounds encounter communication problems with their physicians, and (3) there is evidence, not without controversy, that ethnic minority physicians communicate more effectively with and provide better treatment for patients from similar backgrounds.[2] Extrapolating from these data, we conclude that improving care for disadvantaged patients might be one justification for recruiting more medical students from lower-SES strata. Such reforms could complement cultural awareness programs within medical schools.[1,57,69]

Correlations Between Physicians' and Patients' Social Class

The history of medicine in the United States suggests a correlation between physicians' social class and that of the patients and communities they serve. Historians generally agree that Flexner's reforms, by reducing lower-SES students' access to medical education, reduced lower-SES patients' access to medical care. According to Starr, Flexner's expectation that the new generation of scientifically trained, and more economically privileged, physicians would disperse throughout the country proved wrong.[25] Instead, the physicians settled in wealthier areas. Flexner's reforms thus constitute a "natural experiment" for viewing how a change in physicians' socioeconomic and demographic backgrounds can affect communities' access to medical care.

Although much more research is needed, a study in 1996 confirmed a modest, statistically significant correlation between physicians' social class origins and their service to disadvantaged communities. Cantor et al. report that, after controls for race and sex, physicians of lower SES provide an unusually high share of service to minority, poor, and Medicaid patients.[3] Because this association is weaker and less consistent than that between the race of the physician and the care of disadvantaged communities (and because no association was found in an earlier study),[74] the authors do not support basing affirmative action in medicine on economic disadvantage. Yet, implicitly, they do not rule out class-based affirmative action as a supplement to race-based affirmative action.

In sum, both the historical record and limited research evidence strengthen the argument in favor of recruiting more physicians from lower-SES backgrounds. Such recruitment efforts could work hand in hand with improved insurance coverage and more equitable reimbursement formulas in expanding access to care.

Conclusions

The published research literature on the role of social class in medical education, although not conclusive, suggests that recruiting and admitting more medical students from socioeconomically disadvantaged backgrounds could help advance a variety of health policy objectives. Consequently, medical schools should weigh the possibility of class-based affirmative action. Efforts to expand access to medical education—and medical care—might benefit from considering race, sex, and class in combination because of a history of parallel effects.[25,27] Too often race and sex have overshadowed class in health policy discussions.

The recent challenges to affirmative action offer an unusual opportunity for critical reflection on the role of social class in medical education and have even yielded guidelines for implementing class-based affirmative action. For example, family income is deemed an inadequate measure of SES. Other factors, such as family financial assets (accumulated wealth), parental education, and neighborhood of origin, require consideration.[11–13,17] Questions remain as to appropriate trade-offs between SES and other admissions criteria (e.g., test scores, which are correlated with SES) and the feasibility of higher expenditures on financial aid, which class-based affirmative action would probably necessitate.[17,40] Finally, there are questions as to the impact of class-based affirmative action on the ethnic composition of the medical student body.[11–14]

There is much clearer evidence favoring the continuation of race-based affirmative action in medicine. Expanded racial diversity among physicians has been found to improve access to medical care and ease communication with ethnic minority patients. For many medical schools, the practice of affirmative action extends well beyond the original goal of redressing past discrimination. It is used to increase student diversity and improve health care delivery.[3,4,6]

Medical school administrators and health policymakers would benefit from more research on the ways in which physicians' socioeconomic origins influence their practice and service patterns. Perhaps the recent neglect of this subject reflects what Mechanic has referred to as a decline in sociological awareness in health policy circles.[75,76] It also surely reflects what sociologists have long deemed a characteristically American discomfort with the subject of social class.[11,15,77–79] According to Trow,[77] American researchers do not even gather relevant statistics, such as the percentage of American university students who are of working-class origins. Both Bowen and Bok[17] and Kahlenberg[11–13] confirm the inadequacy of current data on students' SES. By contrast, health policy analysts in other countries—most notably, Frenk et al. in Mexico[80–83]—have explored how their medical education systems might reinforce rather than correct social class inequities.

Medical schools' relative inattention to social class is especially striking in light of their recent efforts to modify and broaden their admissions criteria. Medical schools have begun to evaluate nontraditional factors, such as applicants' value systems and interpersonal skills, in order to enroll more students who will pursue careers in primary care or work with underserved populations.[20,23,71,84–88] There are many precedents for changing medical schools' admissions criteria for the sake of furthering social policy objectives. Class-based affirmative action deserves consideration by medical schools, policymakers, and researchers alike. □

Contributors

Both authors participated fully in the conception, writing, and editing of the paper.

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