Diversification of the health care workforce to better reflect the general population represents an important strategy in achieving health equity, yet racially and ethnically minoritized students and practitioners remain underrepresented across the health professions. This persistent and well-documented problem is restated with added nuance by Majerczyk and colleagues, whose cross-sectional study examines changes over time (2003-2019) in underrepresented minority (URM) and female applicants, matriculants, and degrees awarded for doctor of medicine (MD), doctor of osteopathic medicine (DO), doctor of dental surgery (DDS), doctor of dental medicine (DMD), and doctor of pharmacy (PharmD) programs. Despite noted gains for URM students within schools of dentistry, pharmacy, and osteopathic medicine, allopathic medical schools experienced declines. Across all programs, there were more Asian students but fewer male, American Indian or Alaska Native, Black or African American, Hispanic or Latino, and Native Hawaiian or Pacific Islander students compared with the age-adjusted US Census data. Overall, the results “reveal that underrepresentation remains a widespread concern in health professions education,” and despite the progress made in racial and ethnic and sex diversity, the authors call for additional strategies to achieve a more representative health care workforce.

Given thorough documentation of the underrepresentation of minoritized populations in health professions schools over time and across domains of application, matriculation, and graduation, we contend the moment has arrived to transition decisively from documentation to intervention. Diversity initiatives have long been pervasive in health professions education and have experienced a surge of interest and attention since 2020, but as Majerczyk and colleagues demonstrate, these efforts have failed to correct underrepresentation in the health professions. While many well-intentioned diversity initiatives focus on solutions that target individual URM students, it is crucial to recognize the systemic challenges that contribute to their underrepresentation. Although all students, majority and minority, need support throughout their careers, evidence suggests systemic factors, including bias in assessment and the learning environment, unfairly disadvantage URM students in the health professions. Even before application to health professions programs, for URM students the “leaky pipeline” from undergraduate to professional schools is mired with inequitable opportunities for robust preparation for professional schools, the expensive test-prep industry, and disproportionate risk of disadvantaging childhood and familial socioeconomic factors. Therefore, we call for a decisive shift in focus from placing the onus on the URM student to identifying and implementing evidence-based solutions to address these systemic factors.

The authors provide several suitable suggestions to recruit, retain, and graduate more URM students. In this Invited Commentary, we seek to expand their suggestions by highlighting opportunities to develop interventions to mitigate bias in (1) assessments of students, (2) the learning environment, and (3) the process of recruiting students into health professions schools. Bias in assessments is well documented and affects URM students across their career trajectories. Faculty development programs with ongoing practice and nudges to remind faculty of what they have learned could improve equity in assessment. Institutional investments to provide faculty time and resources to improve their skills in equitable assessment and systemic supports to make it easier to do the right thing (a central tenet in quality improvement) will be paramount.
The learning environment can be conceptualized as the spaces in which students learn and grow in their professional identity formation; it is inclusive of both classroom and clinical settings where the practicum of much of health professions education occurs. Evidence suggests attrition during medical school increases with increasing intersectional marginalized identities, including URM race and ethnicity, low familial income, and coming from an underresourced neighborhood.\(^7\) Even when adjusting for Medical College Admission Test scores to account for presumed individual academic preparation, increased attrition rates persist.\(^7\) Perpetuating the narrative that URM students are unprepared for careers in the health professions is inexcusable, given the evidence. How can we continue to suggest to URM students to strive to just work harder and be better when egregious differences in exposure and impact of negative experiences within the learning environment exist?\(^6\) As health professions educators and clinician-members of the clinical learning environment, we have a collective responsibility to improve the matriculated URM student experience. Negative experiences are likely to deter future URM college students from applying, especially given the power of social media to amplify the reach of personal stories. Improvements in diversity will not be sustainable and scalable by recruiting more diverse individuals into these same alienating environments. We call for research to develop interventions to address bias toward both patients and students as well as other factors to improve the learning environment. Implementation of these interventions must then be driven by leaders with both the responsibility and authority to drive change and to engage practicing clinicians and staff to effect positive change.

Finally, if we seek to improve the number of applicants and matriculants, health professions schools must partner with undergraduate programs at local colleges and universities. As highlighted by Majercyzk and colleagues,\(^2\) pipeline programs are important in encouraging and supporting URM students; however once again, systemic policies and procedures need to be implemented to mitigate individual bias in referring undergraduate students to such programs and to encourage them to pursue careers in health care at the doctoral degree level. URM students face impostor syndrome and stereotype threat,\(^6\) but properly trained faculty, mentors, and career counselors can follow a strengths-based, appreciative approach to guiding students throughout their undergraduate journeys. The microaggressions that often contribute to the leaky pipeline phenomenon can be countered by microaffirmations. Microaffirmations utilized in historically black colleges and universities support excellence and empower students to achieve their dreams (Shani Scott, MD, Montefiore Medical Center, in-person conversation). Academia at all levels can learn from these successful approaches.

In summary, achieving diversity in health professions education is a long-standing, dare we say wicked problem. Diversity initiatives focused on the individual URM student have been around for decades. Majercyzk and colleagues\(^2\) described another systematic approach to evaluate diversity across 4 health professions, yet the results remain the same. The time has come for a seismic shift in our approach to improve diversity in health professions from strategies that promote individual URM student success to evidence-based interventions that can impact the systemic factors that have perpetuated the status quo for decades.
REFERENCES