the administration's rationale, I was told that although developing the early portion of the health-professions pipeline is valuable, "with limited funding we are investing in activities that more directly and immediately impact the supply and distribution of providers." The AAMC took strong exception to the proposed action, saying that the two programs encouraged at least 459,036 members of underrepresented minority groups to consider careers in the health professions and that their elimination would have "dire consequences for the health workforce" and the communities it serves.

Meanwhile, medical educators are increasingly concerned about declining support for affirmative action seen in court cases since the 2003 Supreme Court decision in *Grutter v. Bollinger*, which upheld the race-conscious admissions policy at the University of Michigan Law School. In June 2013, in the first challenge to such policies that the Court has since considered, *Fisher v. University of Texas*, it returned the case to a lower court for further action consistent with its opinion. (On July 15, 2014, responding to that directive, the U.S. Court of Appeals for the Fifth Circuit ruled that the University of Texas could continue using affirmative action in its admission policies.) Darrell G. Kirch, the AAMC chief executive officer, issued a statement, saying, "The AAMC is pleased that the Supreme Court continues to recognize the educational benefits of diversity and the appropriateness of individualized, holistic review in admissions. Diversity is a vital component of excellence in education, clinical care, and research at the nation's medical schools and is a requirement for accreditation by the Liaison Committee on Medical Education." But in the longer term, affirmative action may be on shaky ground, given that five of the nine Supreme Court justices have never voted in favor of race-based considerations in the enrollment processes of medical schools. In addition, eight states have banned race-based affirmative action steps, and others are considering similar actions.[5]

One development that may ultimately expand the diversity of the physician workforce is the impending demographic tsunami. According to the Census Bureau, the proportion of the U.S. population accounted for by racial and ethnic minorities is projected to reach 57% by 2060. In keeping with an ongoing demographic shift among young adults in the United States, the number of white applicants to medical schools has dropped by about 22% over the past three decades. However, the influx of millions of people from other countries — with a wide array of racial and ethnic backgrounds — cannot by itself resolve the diversity challenges facing black Americans and U.S. society.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

Mr. Iglehart is a national correspondent for the *Journal*.

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The New Diversity in Medical Education

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During my pediatrics rotation, the mother of a patient waited until the attending physician had left the room before she lowered her voice, smiled, and asked, "Are you wearing your hoodie for Trayvon?" She didn't know what city I was from, what faith I belonged to, or what tax bracket I was in. She just knew that I was black, like her. This race-based camaraderie between patient and physician can improve patient satisfaction,[1] and patients from racial minority

groups tend to seek out physicians of their own race if given a choice.[2] As a black medical student, I can attest that the sort of "diversity" that you can see — that allows you to be counted in a crowd — can significantly influence interactions with peers, instructors, and patients.

For the past few decades, medical education's definition of "diversity" has largely remained the same, as has the social mandate to increase it. With roots in the Civil Rights Movement, diversity initiatives have focused primarily on racial groups that had been implicitly and explicitly denied access to the field. Efforts to increase the numbers of blacks, Hispanics, and Native Americans served a moral imperative: it was the right thing to do. Such efforts have had mixed results: the proportion of Hispanic medical school graduates increased by 4.1 percentage points from 1978 to 2012, whereas the proportion of black graduates increased by only 1.8 percentage points during the same period (see Perspective article by Iglehart, pages 1471–1474). Moreover, this "good intentions" approach fails to critically examine diversity's true meaning and strips it of its potential to advance the field of medicine.

Enter "Diversity 3.0." The term, coined by IBM, reflects a new way of thinking about diversity in education and the workforce. Building on the 1.0 model, in which diversity was seen as a necessary evil, and the 2.0 version, in which a diverse population was recast as a nice thing for the majority to have around, the current vision defines "achieving the full potential of this diversity [as] a business priority that is fundamental to our competitive success."[3] This reframing is not lost on Marc Nivet, chief diversity officer of the Association of American Medical Colleges. "1.0 is where diversity is competing with excellence," Nivet explains. "Diversity 2.0, which is where we are, has not been viewed as central to the institution's drive for excellence." In addition to integrating diversity into institutions' core missions, the 3.0 version, Nivet has written, "requires a focus on differences beyond race and ethnicity,"[4] the traditional emphases of multicultural affairs offices.

Under this model, medical-student diversity becomes a prerequisite for an optimal learning environment, where various ideas, opinions, and experiences create a breeding ground for innovative solutions to problems. Version 3.0 can thus bridge the gap between initiatives that make black students feel more welcome in medical schools and those that harness the power of a diverse workforce to improve patient care.

Perhaps most immediately, the new vision provides a model for cultural competence in doctor–patient interactions that can improve patient satisfaction. Medical students, for example, can benefit from observing encounters between "standardized patients" (actors hired to play patients) and classmates whose backgrounds may be more similar to those of the hypothetical patients than to their own. My class met one such standardized patient whose religiosity was meant to render her "difficult" — and did have that effect for some students. But having grown up in Texas around many very religious people, I could readily engage in a rather pleasant conversation with her. The classmates who observed it may now approach a similar future patient with greater confidence. Indeed, white graduates of diverse medical schools report that they're better equipped to care for minority patients and have stronger convictions about inadequate access to care.[3] Long after graduation, other benefits of racial and ethnic diversity are evident: black and Hispanic physicians are more likely to practice in areas with larger proportions of black and Hispanic residents, and they see a larger proportion of Medicaid and uninsured patients.[5]

People's worldviews may diverge for many reasons — owing to the experiences of military service, for example, or to sexual orientation or the language one speaks. All such characteristics and experiences figure into the new diversity, which acknowledges that shared experience in this country no longer tracks simply with race. Diversity is not so black and white anymore.

Despite the push for other forms of diversity, medical schools still place a certain premium on "visual diversity" — that of race and sex. This emphasis is understandable: such diversity is easily measurable, and concern about it is a legacy of systemic discrimination. That history, coupled with certain classroom and hospital experiences common to medical students from underrepresented minorities, creates a shared narrative that has supported a collective consciousness for decades. Some minority students may feel that the new diversity puts this

shared identity at risk. And as we aim to translate earlier versions of diversity into something serving medicine's core missions, it's worth remembering that, as with the mother from my pediatrics rotation, I've often quickly built a rapport with a patient simply because we were both black.

But all diversity, visual or not, holds value. It's not just a numbers game or an annual administrative experiment. Diversity is a process that exists outside the admissions cycle and promotional photos. It's a mindset that extends into the classroom and the hospital. If the ultimate goal of diversity in medical schools and residency programs is to improve patient care, a good first step is to create a world where all trainees can feel supported while learning and working to the best of their ability. That goal can be achieved only with a wholehearted commitment to diversity that is inseparable from an institution's identity.

When I started college, I felt drawn to sit with other black students in the cafeteria. But establishing an inclusive learning environment means that people from different walks of life can not only have a seat at the same table but also be comfortable in their chairs. Although embracing this new diversity may mean broadening an institution's outlook from primarily underrepresented racial minorities, efforts targeted at those groups still serve an important mission. Diversity efforts can build on the existing model and borrow from their track record of progress toward creating better medical schools and hospitals for all groups.

When I arrived at medical school, I sought a place where I could be myself. Medical schools pursuing Diversity 3.0 would do well to remember that everyone with a unique story to tell wants the same. The ideal diversity initiative would therefore be a climate control of sorts, striving to create an atmosphere where everyone feels included in the larger dialogue. Only then will the conditions be ideal for creating a workforce that's willing and well-equipped to address the needs of an increasingly diverse population.

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Achieving and Maintaining Polio Eradication — New Strategies

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It has been nearly 2 years since the last known case of type 3 poliomyelitis occurred in Nigeria, and although it's still too early to celebrate, the disappearance of the second of the three poliovirus serotypes (type 2 transmission was eliminated in 1999) represents a major milestone and proof of principle that global eradication of paralytic poliomyelitis is achievable.

Poliovirus transmission has been identified in 10 countries this year, but more than 75% of the cases have occurred in Pakistan, where antigovernment militants have denied immunization to more than 300,000 children for more than 2 years. This summer, military activities opened some areas to vaccination teams and provided an opportunity to deliver oral polio vaccine (OPV) with other basic health services to displaced children and families, while also creating a risk of dispersal of poliovirus-infected persons more broadly in the region. Multiple supplemental im-