

HEALTH LAW: PEER-REVIEWED ARTICLE

How Has American Constitutional Law Influenced Medical School Admissions and Thwarted Health Justice?

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Abstract

Medical schools have sought to diversify their classes to motivate inclusion, to draw upon the educational benefits of diversification, to promote educational opportunity, to facilitate representation of persons with minoritized identities in the US physician workforce, and to advance racial and ethnic equity in health status and access to health services regionally and nationally in the United States. The US Supreme Court has allowed schools' race-conscious admissions when their purpose is to diversify an incoming class but not to remediate inequity. This article explains why this limit to affirmative action laws' implementation blunts medical schools' capacity to do their part to secure health justice for all in the United States. Since the Supreme Court is poised to rule more narrowly on affirmative action law again, this article also considers key threats to health justice posed by further limiting or eliminating race-conscious admissions.

Always Unequal

Kevin Outterson has argued that “[f]or as long as records have been kept, studies have reported racial differences in health care access and health status in the United States.”¹ Evidence for this claim is thoroughly documented in the Institute of Medicine’s seminal 2003 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.² The report states: “[a]t no time in the history of the United States has the health status of minority populations—African Americans, Native Americans, and, more recently, Hispanics, and several Asian subgroups—equaled or even approximated that of white Americans”² and recognizes inequity as a result of **structural racism** in American society.

One way to promote health equity is to make the physician workforce and medical student bodies more representative of the US population. For example, Black physicians are still underrepresented relative to Black people’s share in the population.³ In 2018, only 5% of the physician workforce was African American, although African Americans composed 13% of the US population.⁴ Increasing physician diversity is key to health equity, as patient-physician **racial concordance** can make a “difference between life and death.”⁵ For example, that “[i]nfant mortality is halved when Black newborns are cared

for by Black rather than White physicians”⁵ represents a significant narrowing of an egregious mortality gap that should reinforce efforts to increase diversity in medical school classes, which can positively influence population health downstream and thereby reduce health inequity.

This article discusses the harms caused by lack of racial diversity in the physician workforce, landmark Supreme Court cases involving affirmative action policies, and the possible fate of race-conscious medical school admissions at the hands of a newly constituted Supreme Court.

Physician Diversity

Medical school faculty remain predominantly White, and the environment of academic medicine is hostile to many Black, Indigenous, and people of color (BIPOC).⁶ For example, in January 2020, Uché Blackstock, the founder and chief executive officer of Advancing Health Equity, left academic medicine, noting a “toxic and oppressive work environment that instilled in me fear of retaliation for being vocal about racism and sexism within the institution.”⁷ Many academic health centers’ displays of portraiture represent

“whiteness, elitism, maleness, and power,” suggesting to many BIPOC students that “[t]his institution was never meant for me.”⁸

In light of the racial inequity in and unwelcoming environment of academic medicine, physicians in academic health centers are becoming more aware of how racial inequity is built into health care and into health professions education, recognizing that the “next frontier for health justice” is “structural and policy change.”⁹ One key change will require recruitment and enrollment of diverse students. Marc Nivet, former chief diversity officer at the Association of American Medical Colleges, notes that there are “three distinct phases in the evolution of diversity” in medical school admissions.¹⁰ The first phase began in response to civil rights movements and focused on changing “institutional head counts and student retention rates”; the second phase began in the 1980s, when medical schools started incorporating initiatives to foster the success of minority students and faculty, thereby increasing schools’ “openness to the notion that diversity and excellence are not only complementary but inextricably linked.”¹⁰ Nivet argues that medical schools are poised to enter a third phase that “requires a mental shift that frames diversity as a means to address quality health outcomes for all, rather than an end goal in and of itself.”¹⁰ According to Nivet, “[d]iversity work must be seen as more than just solving the problem of inadequate representation and alleviating the barriers facing disadvantaged and marginalized populations” and must focus on “developing a culture of inclusion” that “enhances the experience of all medical students, faculty, and, most important, patients.”¹⁰

A diverse and inclusive health care workforce is, as Terri Laws notes, “fundamental to implementing the revolutionary change required to achieve health equity.”¹¹ Black patients report higher levels of distrust in physicians and the health care system than White patients,¹² and, as the authors of the study note, “[t]hese differences are generally attributed to current and historical evidence of inequitable treatment.”¹² Because “trust has long been recognized as a fundamental component of the physician-patient relationship,” it is associated with treatment adherence and health status.¹² Racial or ethnic concordance promotes not only trust,¹³ but also “patient satisfaction, better communication, and shared decision making,” which in turn produce better health outcomes.¹¹ Diversity also enhances cultural humility by “enabling health care and social service workers to provide effective access and care to patients with diverse

values, beliefs, and practices,” with the primary goal being to “contribute to the elimination of racial and ethnic gaps in health outcomes.”¹⁴ Yet diversification has been **legally challenged** on equal protection grounds, and medical schools must abide by court rulings about race-conscious admissions.

Constitutional Law

Race-based affirmative action cases have been key in equal protection constitutional jurisprudence for over 50 years. In the 1960s and 1970s, universities increased diversity on their campuses in the wake of the civil rights movement.¹⁵ It was not long before race-based affirmative action policies were challenged in courts, alleging violation of the Fourteenth Amendment’s Equal Protection Clause.¹⁶ The US Supreme Court “was repeatedly asked to consider whether ‘benign’ race-conscious policies [eg, affirmative action] were constitutionally distinct from the race-based classifications that characterized Jim Crow and ‘separate but equal.’”¹⁷ Such challenges lead to the seminal case, *Regents of University of California v Bakke*,¹⁸ in which the Supreme Court issued its first major ruling on race-based affirmative action policy that has informed decisions about such policies’ legality ever since.

Bakke decision. The *Bakke* decision grew out of a case challenging the University of California Davis School of Medicine’s race-based admission policy that used a quota.¹⁸ The medical school’s policy aimed to remedy past social wrongs by explicitly carving out space in its classes for BIPOC students. The court, applying strict scrutiny, ultimately rejected the school’s admission policy, with Justice Lewis Powell finding “societal discrimination” to be “an amorphous concept of injury that may be ageless in its reach into the past.”¹⁸ However, the court accepted that “a university properly may consider” diversity for purposes of “attaining the goal of a heterogeneous student body.”¹⁸ A fundamental legal legacy of *Bakke* is that, while it allowed affirmative action to promote diversity within a class, the remedial rationale for diversity is significantly circumscribed, and, as Jennifer Jones notes: “since 1978 courts and universities have diverted their attention from mitigation of the impact of past and present racial discrimination to safeguarding the diversity rationale.”³

Rationales for race-conscious admissions. In the years since *Bakke*, the Supreme Court has upheld diversity as a rationale for race-conscious admissions that survives strict scrutiny. Twenty-five years after *Bakke*, the Supreme Court sanctioned “holistic” review of applicants in *Grutter v Bollinger*,¹⁹ requiring admissions committees “to show that they had conducted a holistic review of candidates in which race was one factor among many considered” while eschewing quotas and considering “race-neutral alternatives.”³ Subsequently, *Fisher v University of Texas at Austin (Fisher I)*²⁰ required that “admissions committees convince the trial court that the use of race is necessary to achieve the compelling state interest it aims to serve.”³ *Fisher I* established 3 governing principles for assessing the constitutionality of affirmative action programs: (1) racial classifications are “necessary to achieve the state’s interest” (ie, the constitutional strict scrutiny standard); (2) quotas are impermissible, although admission programs are entitled “some judicial deference”; and (3) “universities are owed no deference in determining whether their use of race is narrowly tailored.”³ Instead, universities must “bear the significant burden of proving that a ‘nonracial approach’ [to their attempts to diversity admissions] would not effectively promote the state interest in its admissions model.”³ These principles make clear that, while the Supreme Court allows race to be used in admissions decisions, the constitutional standard for its use is strict and not without burden.

Most schools meet this standard by implementing **holistic review** of candidates, as sanctioned in *Grutter*. This approach, which “the vast majority of medical schools” use today in some form “in their admissions process”²¹ can incorporate consideration of race and culture, along with other factors. Ideally, holistic review encourages selection based on a candidate’s “experiences, attributes, and academic metrics equally,”²² and functions as a “flexible, individualized way of assessing an applicant’s capabilities.”²¹ Although holistic review has been sanctioned by the Supreme Court as constitutionally permissible,²¹ in practice, it is not wholly effective, given persistent racial inequity in the physician workforce and medical student bodies. Systemic inequity requires an approach mindful of race and racial inequity when making admissions decisions and policy—seeking diversity in a class is not enough. For example, there is evidence that admissions committee members’ implicit racial bias exacerbates “relative lack of diversity in medical school,”²³ underscoring medical schools’ need to do more to motivate inclusion.

Constitutionally permissible practices (ie, using the diversity rationale and employing a holistic approach to diversity) are insufficient to remedy systemic inequity. One critic of the *Bakke* legacy notes that, by sanctioning the diversity rationale and eliminating the remedial rationale, the Supreme Court “wrote into law resistance to the notion that America has moral debts to account for” and instead “introduced a colorblind approach to its analysis of affirmative action in higher education.”³ Jones explains that, by endorsing “a false equivalency between laws intended to subordinate Black people [ie, Jim Crow] and laws intended to remedy the effects of anti-Black discrimination [ie, affirmative action],” the Supreme Court effectively created a “weaponization of the Equal Protection Clause’s original meaning.”³

Reasons for Concern

Some scholars see an opening for the Supreme Court to allow a rationale for race-conscious admissions whose main purpose is to effectuate health equity. Former Secretary of Labor Tom Perez calls for the court to sanction a rationale that would base affirmative action policies on a goal of “increasing access to health care for the poor, underserved, and minority communities and progress in eliminating racial and ethnic disparities in health status.”²⁴ Perez notes that such an “access rationale” has a potential opening in the *Bakke* opinion itself, as the court “did not dismiss this [remedial] rationale out of hand” and explained that it may be constitutional when there is sufficient evidence to demonstrate that “a state’s interest in increasing access to health care in underserved communities ‘is sufficiently compelling.’”²⁴ Back in 1978, the court found no sufficient evidence, but, since that time, “a wealth of empirical data has emerged, demonstrating that increasing racial and ethnic diversity in the health professions will increase access to health care in underserved, minority communities,” and facilitate health equity.²⁴ Were such a rationale to be found by the court to be constitutional, it would likely have greater impact on physician workforce equity and health outcomes equity than the diversity rationale.

While it is theoretically possible that the Supreme Court could strengthen race-conscious admissions by sanctioning an access- or health justice-based rationale that satisfies the Equal Protection Clause, there is an actual risk that race-conscious admissions for any purpose could be eliminated by the US Supreme Court. The court is considering ruling on an affirmative action case filed against Harvard University,²⁵ in which the claimants allege that Harvard’s use of race in admissions violates the civil rights of some groups, particularly Asian Americans.²⁶ Nancy Zisk discusses the possibility of the court

overturning precedent for constitutionally sanctioned race-conscious admissions to “ban any consideration of race in admission[s decisions].”²⁷ In June 2021, the Supreme Court delayed taking up the Harvard case, requesting the Biden administration’s solicitor general to first weigh in. If the court does review the case, it will do so absent Justices Anthony Kennedy and Ruth Bader Ginsberg, whose presence on the court narrowly upheld race-conscious admissions in *Fisher II*.^{28,29} While it is unknown what the court will do, the court’s 6-3 conservative majority composition could roll back race-conscious admissions somewhat, if not entirely. If Justice Stephen Breyer does not retire during a democratic administration (or Senate majority), a 7-2 conservative court is also possible.³⁰

Harms caused by blocking race-conscious admissions are already well documented. In 1996, California voted to ban racial preference admissions at its state universities; this act decreased numbers of Black and Hispanic students in University of California schools.^{31,32} One provost noted: “The quality of our education experience is absolutely affected, as well as our obligation to the citizens of this state.”²⁶ If the Supreme Court further erodes race-conscious admission considerations to a level analogous to the California ban, medical schools and the profession of medicine will need other means of averting homogeneity and perpetuating health inequity.

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