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Brief of Amici Curiae Committee of Interns and Residents SEIU; Doctors Council SEIU; and Korean American Medical Association in Support of Respondent

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No. 12-484

IN THE

Supreme Court of the United States

UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER,

Petitioner,

v.

NAIEL NASSAR, M.D.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF *AMICI CURIAE* COMMITTEE OF INTERNS AND RESIDENTS SEIU; DOCTORS COUNCIL SEIU; AND KOREAN AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICI CURIAE*[1]

The Committee of Interns and Residents SEIU, ("CIR") is the primary national voice for resident physicians in the United States. CIR represents more than 13,000 resident physicians who provide healthcare to diverse populations in Massachusetts, New York, New Jersey, Florida, New Mexico, California, and the District of Columbia. CIR is keenly aware of the importance of a diverse, culturally competent physician workforce in order to provide safe and effective healthcare and to address health disparities. Due to its leadership in the quality improvement movement, CIR is well-attuned to the multiple and proven benefits of breaking the wall of silence in the healthcare setting. As an organization that has represented employed professionals for more than fifty years, CIR is well aware of discrimination and fear of retaliation in the medical profession. CIR strongly believes that the healthcare system will be unable to address pervasive discrimination unless physicians and others who experience or observe discrimination in the workplace are able to report the facts to their employer and have them investigated, without fear of retaliation.

Doctors Council SEIU is a labor organization that represents approximately 3,000 attending physicians in the public and private sector in New York, New Jersey,

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1. No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than the *Amici Curiae* or their counsel made a monetary contribution to its preparation or submission. Letters evidencing the parties' blanket consent to the filing of *amicus* briefs have been filed with the clerk.

Pennsylvania, and Illinois. Many of our members are attending physicians employed by medical schools and professional corporations in teaching hospitals. Almost all are employed to treat the diverse and medically underserved population that depends upon our public hospitals and health care facilities for their medical needs. Doctors Council SEIU's interest in this case is in protecting employed physicians against unlawful discrimination and retaliation in their workplaces. Minority and women physicians are essential to the effective provision of health care to the diverse population that makes up our nation.

The Korean American Medical Association ("KAMA") is a non-profit organization of Korean American physicians across the United States. Founded in 1974, our mission is to unite physicians of Korean heritage to further global interaction and better the world through the sharing of medical knowledge and skills. Additionally, KAMA works to help Korean American physicians excel in all aspects of their medical career. Workplace discrimination and legal rules that inhibit doctors from alleging discrimination interferes with this mission. Further, a number of KAMA's members are international medical graduates, and KAMA is well aware of the challenges that they face in the workplace.

INTRODUCTION AND SUMMARY OF ARGUMENT

Title VII's antiretaliation provision undergirds its antidiscrimination provisions by providing a safe harbor for employees who allege discrimination before a court, administrative agency, or the employer itself. In turn,

the availability of the mixed-motive framework, first articulated in *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989), renders Title VII's antiretaliation provision more effective by relieving plaintiffs of the significant hurdle of proving in the first instance that the employer would have made a different decision in the hypothetical situation in which it had not been motivated by retaliatory animus.

Without an effective safe harbor, employees may feel that their safest course of action is to remain silent or seek alternative employment. However, neither silence nor exit does anything to prompt an employer to reform its employment practices. Thus, a pattern of discrimination followed by exit may result, ultimately reducing diversity in the medical profession.

When this dynamic occurs in academic medical environments like the University of Texas Southwestern Medical Center ("UTSW"), it harms not just employees, but also the quality of medical training and research, ultimately to the detriment of patients. A growing body of medical literature confirms that "[d]iversity among faculty enhances the ability of academic medicine to fulfill its educational, research, and patient-care missions," and "improves the quality of medical education,"[2] ultimately benefiting patients. The American Medical Association ("AMA") itself has recognized that a diverse medical profession is more likely to provide culturally effective health care and decrease disparities in the provision of

2. Linda Pololi et al., *Race, Disadvantage and Faculty Experiences in Academic Medicine,* J. Gen. Internal Med. 1363, 1363 (2010).

health care along racial and ethnic lines.[3] Similarly, the Association of American Medical Colleges ("AAMC")[4] recently stated that the benefits of diversity in the medical education environment "are particularly important because public health is at stake, not just business interests,"[5] and that diversity is a core component of medical education that "drive[s] excellence and improve[s] patient care for all."[6]

Discrimination, though, interferes with this goal of achieving diversity. It is well documented that discrimination against minorities and women in academic medicine is a pervasive and serious problem. According to AAMC, there is "little real racial and ethnic diversity in academia and even less in leadership positions."[7] Further, a growing body of evidence shows that "race/ethnicity,

3. *See* Br. for Association of American Medical Colleges et al. as *Amici Curiae* in Support of Respondents, Fisher v. University of Texas, No. 11-345, at 9-10 (Aug. 13, 2012) [hereinafter *AAMC Fisher Br.*] (identifying diversity in health profession as key to helping to eliminate racial and ethnic health disparities and to provide care to diverse society). The American Medical Association participated as *amicus curiae* on this brief. *Id.* at 2.

4. The American Association of Medical Colleges has filed an *amicus* brief in support of defendant UTSW in this case. *See* Br. for American Council on Education and Six Other Higher Education Organizations as *Amici Curiae* in Support of Petitioner, University of Texas Southwestern Medical Center v. Naiel Nassar, No. 12-484 (Mar. 11, 2013).

5. *AAMC Fisher Br.*, *supra*, at 13.

6. Association of American Medical Colleges, *Striving Toward Excellence: Faculty Diversity in Medical Education*, 4 (2009) [hereinafter AAMC, *Striving*].

7. *Id.* at 1.

gender, and foreign-born status often provoke bias and result in cumulative advantages or disadvantages" at work, which impact "faculty recruitment, promotion, and retention."[8] Studies have also found that minority faculty members are less likely to receive tenure and are promoted at lower rates than their white counterparts, and often perceive discrimination in their workplaces.[9]

Discrimination in academic medicine is exacerbated by a culture of workplace silence. Accordingly, it is critical that Title VII's antiretaliation provisions remain a viable source of protection for victims of discrimination who seek redress from their employers or the courts. Eliminating the mixed motive framework would threaten the willingness of physicians and other employees to take steps to oppose discrimination, ultimately harming the provision of medical care.

ARGUMENT

I. Requiring Plaintiffs to Prove That Their Employers Would Have Made a Different Decision Absent a Retaliatory Motive Would Undermine Title VII's Protections Against Discrimination.

In *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989), six Justices rejected the view that plaintiffs suing under the antidiscrimination provisions of Title VII were required to prove not only that bias infected their employers' decisions, but also that those decisions "would have been different if the employer had not discriminated." *Id.* at 237-

8. *Id.* at 8 (citation omitted).

9. *See infra* Part II.

38 (opinion of Brennan, J.). While the six Justices differed in some respects, all agreed that, at minimum, when a plaintiff has "shown by a preponderance of the evidence that an illegitimate criterion was a *substantial* factor in an adverse employment decision, the deterrent purpose of the statute has clearly been triggered." *Id.* at 265 (opinion of O'Connor, J., concurring) (emphasis in original); *see also id.* at 259-60 (opinion of White, J., concurring) (concluding that when a plaintiff has shown that discriminatory motive was "a *substantial* factor in the adverse employment action . . . . [t]he burden of persuasion then should have shifted to Price Waterhouse" to show that it would have made the same decision absent the discriminatory motive) (emphasis in original). Accordingly, under *Price Waterhouse*'s mixed motive framework, once a plaintiff has shown that discrimination played a substantial role in the employer's decision, the employer is then tasked with showing that it would have made the same decision even in the counterfactual situation in which it was not motivated by discrimination.

Following *Price Waterhouse*, Congress amended Title VII, finding that "additional remedies under Federal law are needed to deter unlawful harassment and intentional discrimination in the workplace." Pub. L. No. 102-166, § 2(1), 105 Stat. 1071 (1991); *see also id.* § 3(4) (1991 Amendments designed to "respond to recent decisions of the Supreme Court by expanding the scope of relevant civil rights statutes in order to provide adequate protection to victims of discrimination"). The 1991 Amendments confirmed that mixed motive liability will lie in cases in which a plaintiff shows that "race, color, religion, sex, or national origin was a motivating factor

for any employment practice." 42 U.S.C. § 2000e-2(m).[10] Further, the 1991 Amendments made the "same decision" defense relevant only at the remedy phase, limiting plaintiffs whose employers would have taken the same action even without discriminatory animus to declaratory and injunctive relief, and attorney's fees and costs. *Id.* § 2000e-5(g)(2)(B)(i).

Remarkably, UTSW argues that by failing to list retaliation in the mixed motive provisions of the 1991 Amendments, Congress actually *heightened* the proof required of mixed motive retaliation plaintiffs by limiting liability to cases where the plaintiff could show that retaliation was the but for cause of the challenged adverse employment action in the first instance. However, this reading is inconsistent with the text, history, and purpose of the 1991 Amendments.[11] In particular, *amici* urge this Court to interpret Title VII's antiretaliation provision in light of Congress's explicit deterrence goal. *See Kasten v. Saint-Gobain Performance Plastics Corp.*, 131 S. Ct. 1325, 1333 (2011) (interpreting FLSA antiretaliation provision in light of "functional considerations").

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10. In *Price-Waterhouse*, Justices O'Connor and White used the phrase "substantial factor" to characterize the plaintiff's initial burden, 490 U.S. at 259 (opinion of White, J.); *id.* at 265 (opinion of O'Connor, J.), whereas Justice Brennan used the phrase "motivating factor," *id.* at 250. This distinction, though, is one without a difference, because this Court uses those phrases interchangeably. *Mt. Healthy Sch. Dist. Bd. of Educ. v. Doyle*, 429 U.S. 274, 287 (1977).

11. *Amici* will not repeat the Respondent's arguments on this point, but adopts them as if fully articulated herein.

Antiretaliation provisions make Title VII's enforcement scheme effective by preventing fear of retaliation from inducing workers to remain silent in the face of illegal treatment. *Kasten*, 131 S. Ct. at 1333 ("antiretaliation provision makes [FLSA] enforcement scheme effective by preventing 'fear of economic retaliation' from inducing workers 'quietly to accept substandard conditions'" (citation omitted)); *Crawford v. Metro. Gov't of Nashville & Davidson Cnty.*, 555 U.S. 271, 279 (2009) (citing studies showing "fear of retaliation is the leading reason why people stay silent instead of voicing their concerns about bias and discrimination") (internal quotation marks, citation, and brackets omitted); *Burlington N. & Santa Fe Ry. Co. v. White*, 548 U.S. 53, 63 (2006) (retaliation provision of Title VII "seeks to secure that primary objective" of ending workplace discrimination). Without adequate protections against retaliation, employees who have been discriminated against—those who have been harassed, for example, or demoted because of their race—may rationally decide to remain silent until they are out of their employer's reach, in other words, until they quit or are fired.

Requiring mixed motive retaliation plaintiffs to prove but for causation without the benefit of the mixed motive framework could have grave consequences in the context of academic medicine—a context already plagued by organizational cultures that reinforce silence.[12] When

12. *See* Kerm Henriksen & Elizabeth Dayton, *Organizational Silence and Hidden Threats to Patient Safety*, 41 Health Serv. Res. 1539-40 (2006) (reporting recent study in which "fewer than 10 percent of physicians, nurses, and clinical staff directly confronted their colleagues when they became aware of poor clinical judgment or shortcuts that could cause harm" and "[o]ne in five physicians said they have seen harm come to patients as a result") (citation omitted).

asked why employees declined to speak up about problems at work, department chairs in medicine and surgery from 127 U.S. academic health centers ranked "belief that speaking up will be ignored" as the number one reason, with "fear of repercussions" ranked either second (among medicine chairs) or third (among surgery chairs). Wiley Souba et al., *Elephants in Academic Medicine*, 86 Acad. Med. 1492, 1494 (2011). Within this context of organizational silence, minority doctors often face the difficult choice of "trying to decide when to confront bias and stereotypes in the workplace without negatively impacting their career development at an institution." *See* Eboni Price et al., *The Role of Cultural Diversity Climate in Recruitment, Promotion, and Retention of Faculty in Academic Medicine*, 20 J. Gen. Internal Med. 565, 568 (2005) (silence about bias and stereotypes as a choice related to an institution's "climate of diversity"); *see also* Marcella Nunez-Smith et al., *Race/Ethnicity and Workplace Discrimination: Results of a National Survey of Physicians*, 24 J. Gen. Internal Med. 1198, 1202 (2009) (2006-2007 national survey showing minority physicians felt less comfortable than white physicians communicating about race or ethnicity at work). These doctors often choose silence instead of informing their supervisors and employers about perceived discriminatory treatment. *See* Alice A. Tolbert Coombs & Roderick K. King, *Workplace Discrimination: Experiences of Practicing Physicians*, 97 J. Nat'l Med. Assoc. 467, 470 & 473 (2005) (though 63% of respondents experienced at least one form of discrimination, only 11.3% of respondents reported an incident of discrimination).[13]

13. Furthermore, of the relatively small number of physicians who reported discrimination, nearly 70% of respondents found themselves either worse or no better off for having done so. Coombs & King, *supra*, at 473.

However, when physicians and other employees do not report discrimination at all, or when they wait to report until they have quit or been fired, they miss the opportunity to use "desirable informal workplace grievance procedures to secure compliance with the Act." *Kasten*, 131 S. Ct. at 1334 (citing *Burlington Indus., Inc. v. Ellerth*, 524 U.S. 742, 764 (1998)). Thus, contrary to the suggestions of Petitioner and its *amici* that the mixed-motive framework of the 1991 Amendments or *Price Waterhouse* will drive baseless litigation, robust retaliation protections can help employers avoid lawsuits by encouraging employees to come forward when they first begin to suspect discrimination. *See Crawford*, 555 U.S. at 278-79 (citing petitioner's brief, which in turn cited studies showing that employers strengthened internal procedures for responding to discrimination complaints in response to *Ellerth* and *Faragher v. Boca Raton*, 524 U.S. 775 (1998)).[14]

This case reflects two primary reasons that employees remain silent – that speaking out will either do nothing,

14. This view of the function of antiretaliation provisions accords with studies of effective workplace management. Employees are more likely to feel free to speak out and supply critical information to employers when they believe that managers "mak[e] decisions that . . . are also consistent, accurate, correctable, and suppress any bias," referred to as a positive procedural justice climate. Subrahmaniam Tangirala & Rangaraj Ramanujam, *Employee Silence on Critical Work Issues: The Cross Level Effects of Procedural Justice Climate*, 61 Personnel Psychol. 37, 39, 42 (2008). The threat of retaliation, then, defeats the creation of such a "procedural justice climate." *Id.*

or it will be punished.[15] After Dr. Nassar experienced what he perceived as discriminatory treatment from his immediate supervisor, Dr. Beth Levine, JA 24, 34, 243, 311, he discussed the incidents with Dr. J. Gregory Fitz, at that time the chair of internal medicine. JA 205-10. After no action was taken, JA 210, Dr. Nassar sought other work and ultimately resigned his position at UTSW, believing he had secured another job. JA 24 & 311-15. In his letter of resignation, Dr. Nassar described in more detail the discrimination that he suffered. JA 24-25 & 311-13. Dr. Nassar also sent his letter to additional UTSW representatives, including the UTSW president, and an external organization, the Dallas-Fort Worth office of the Council on American-Islamic Relations. JA 311.

Then, as a jury later found and the Fifth Circuit upheld, Dr. Fitz retaliated against Dr. Nassar, directing the rescission of his new job offer. *Nassar v. Univ. of Tex. Sw. Med. Ctr.*, 674 F.3d 448, 451 (2012). Having resigned his position at UTSW and with the Parkland job blocked, Dr. Nassar left for a less prestigious position. *Id.* This dynamic—in which an employee who reports discrimination is punished—only reinforces an institutional culture of silence, by sending the clear message that reporting discrimination can be dangerous to one's career.

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15. *See* Elizabeth Wolfe Morrison & Frances J. Milliken, *Organizational Silence: A Barrier to Change and Development in a Pluralistic World*, 25 Acad. Mgmt. Rev. 706, 714 (2000) (organizational silence exists when employees believe that "(1) speaking about problems in the organization is not worth the effort, and (2) voicing one's opinions and concerns is dangerous").

Title VII's antiretaliation provision can play its part in effectuating the statute's discrimination protections and in promoting internal reporting of discrimination only if employees have a reasonable chance to prove retaliation in court. A framework that requires plaintiffs to prove in the first instance that a hypothetical decision-maker—one that lacked retaliatory animus—would have made a different decision would leave many retaliation victims without a remedy. *See NLRB v. Transp. Mgmt. Corp.*, 462 U.S. 393, 403 (1983) (upholding NLRB's treatment of "same decision" affirmative defense and observing that "[i]t is fair that [the employer] bear the risk that the influence of legal and illegal motives cannot be separated, because he knowingly created the risk and because the risk was created not by innocent activity but by his own wrongdoing"). This is particularly so when multiple people work together to arrive at an employment decision, as regularly occurs in academic workplaces. *See* Paul R. McHugh, *A "Letter of Experience" About Faculty Promotion in Medical Schools*, 69 Acad. Med. 877, 880 (1994) ("decision for promotion rests on a judgment of peers who, *in committee*, reflect on all aspects of the nominee's career") (emphasis in original). In cases involving multiple decision makers, plaintiffs would have to prove not only that retaliation played a motivating or substantial role in the employment decision, but also that enough decision makers had enough retaliatory intent for that motive to predominate over the various additional motivations that might have also been at work. "Particularly in the context of the professional world, where decisions are often made by collegial bodies on the basis of largely subjective criteria, requiring the plaintiff to prove that *any* one factor was the definitive cause of the decision makers' action may be tantamount to declaring Title VII

inapplicable to such decisions." *Price Waterhouse*, 490 U.S. at 273 (opinion of O'Connor, J.) (emphasis in original).

Strong antiretaliation protections, including the availability of the mixed motive framework, help create the kind of workplace climate that promotes reporting of discrimination. Conversely, diminished protections, such as the "but for" standard advocated by UTSW, would make talented physicians, teachers, and researchers like Dr. Nassar even more reluctant to come forward regarding discrimination in academic medicine, allowing that discrimination to flourish. In the next section, *Amici* describe the extent to which discrimination now occurs in academic medicine, and on the threat it poses to public health.

II. Workplace Discrimination by Medical Schools Negatively Impacts the Training of Medical Professionals, the Provision of Healthcare, and the Advancement of Medical and Scientific Knowledge.

Quantitative and qualitative studies consistently reveal pervasive discrimination against minority and female faculty members at medical schools. According to these studies, minorities are less likely to be promoted than white faculty, report lower career satisfaction, and transition out of academia sooner than other faculty.[16] This can cause a vicious cycle: having less authority, prestige, or status can make one more vulnerable to retaliation, meaning that one consequence of discrimination in hiring and promotion is to leave victims of discrimination more vulnerable if they report.

16. *See infra* nn. 19-23 & accompanying text.

Furthermore, as the AMA and AAMC have both recognized, serious adverse consequences arise from pervasive discrimination in the medical field. These consequences include underrepresentation of minorities and women among medical school faculty, which in turn impairs the provision of the best science, education, and medical care.[17]

Studies of medical schools have documented that a substantial number of minority and female faculty members experience discrimination in the workplace.[18] For

17. For example, in addressing the need to diversify medical school faculties, the AAMC has called for a "culture change" in academic medicine, one that reframes diversity from being merely a tool benefitting minorities "to a core ingredient that propels excellence in research, teaching and clinical practice." *See* AAMC, *Striving, supra,* at 17. *See also* Pololi et al., *supra*, at 1363 ("[f]ailure to fully engage the skills and insights of [under-represented minority] faculty impairs our ability to provide the best science, education or medical care").

18. A similar dynamic operates more broadly in the medical profession. A national cross-sectional survey conducted in 2006-2007 found that 71% of black physicians, 45% of Asian physicians, 63% of "other" race physicians, and 27% of Hispanic/Latino(a) physicians reported having experienced racial/ethnic discrimination during their medical career. Nunez-Smith et al., *Race/Ethnicity and Workplace Discrimination*, *supra*, at 1200. This same survey found that 59% of black, 39% of Asian, 35% of "other" race, and 24% of Hispanic/Latino(a) physicians reported experiencing discrimination in their current work setting. *Id.* These high rates of reported workplace discrimination occurred regardless of specialty, geographic region, gender, years in practice, or age. *Id.* at 1203. These findings are consistent with numerous studies that have examined discrimination against minorities, women, and IMGs in the medical profession. *See, e.g.*,

example, in one national study of 1,979 full-time medical school faculty members at twenty-four randomly selected U.S. medical schools, nearly half of underrepresented minority doctors reported that they had personally experienced racial or ethnic discrimination either in their professional advancement or from a superior or colleague; some of their white colleagues also reported perceiving racial or ethnic bias in the work environment, but far fewer reported personally experiencing the effects of that bias.[19] The results of that study are as follows:

Coombs & King, *supra*, at 467 (study of Massachusetts physicians finding that over 60% of respondents believed discrimination against IMGs was very or somewhat significant; 48.1% believed racial discrimination was very or somewhat significant; 43.2%, gender discrimination); Miriam Komaromy et al., *Sexual Harassment in Medical Training*, 328 New Eng. J. Med. 322, 322 (1993) (noting study of female physicians that reported that 27 percent had been sexually harassed in the preceding year).

19. Neeraja B. Peterson et al., *Faculty Self-reported Experience with Racial and Ethnic Discrimination in Academic Medicine*, 19 J. Gen. Internal Med. 259, 263 (2004) (Table 2: Perception and Experience of Racial/Ethnic Bias by Minority Status; underrepresented minorities include African Americans, Mexican Americans, Puerto Ricans, and Native Americans; nonunderrepresented minorities include Asian Americans and other Hispanics).

	Under-represented Minorities	Non-Under-represented Minorities	Whites
Reported perception of racial or ethnic bias	63%	50%	29%
Reported personally experiencing racial or ethnic discrimination	48%	26%	7%

Minority faculty also report experiencing structural barriers to academic success and career satisfaction.[20]

Reports of discrimination by minority faculty members are consistent with documented racial and ethnic disparities in faculty promotion and tenure. *See, e.g.*, Anita Palepu et al., *Minority Faculty and Academic Rank in Medicine*, 280 J. Am. Med. Assoc. 767, 767 (1998) (minority faculty less likely than whites to be promoted to senior rank); Robert G. Petersdorf et al., *Minorities in Medicine: Past, Present, and Future*, 65 Acad. Med. 663 (1990) (minority faculty typically promoted to associate professor three to seven years later than white faculty). The most extensive study of faculty promotion in academic medicine found that minority faculty were less likely to be

20. Peterson et al., *supra*, at 263; Price et al., *supra*, at 568 (minority faculty have reported observing or experiencing significant levels of bias in recruitment efforts for faculty, fellowship and resident appointments).

promoted or to hold senior faculty rank when compared to white faculty, even after controlling for cohort, sex, tenure status, degree, department, medical school type, and receipt of National Institutes of Health research awards. Di Fang et al., *Racial and Ethnic Disparities in Faculty Promotion in Academic Medicine*, 284 J. Am. Med. Assoc. 1085, 1090-91 (2000) (examining 50,145 full-time US medical school faculty who became assistant or associate professors between 1980 and 1989, separated into five two-year cohorts, assessing attainment of promotion by 1997). And, minority assistant professors experienced lower rates of promotion in every cohort when compared with white professors, regardless of tenure-track status or having served as principal investigators on NIH research awards, even as their representation in academic medicine increased. *Id.* at 1089-90.[21]

National AAMC data has further documented that minority and female faculty members are leaving academic medicine at a higher rate than their white, male counterparts.[22] Several studies have found

21. A similar pattern was observed for underrepresented minorities who were at the associate professor level between 1980 and 1989. Fang et al., *supra*, at 1090. *See also* Marcella Nunez-Smith et al., *Institutional Variation in the Promotion of Racial/Ethnic Minority Faculty at US Medical Schools*, 102 Am. J. Pub. Health 852, 856 (2012) (finding on average that promotion rates for Hispanic and Black academic medical center faculty were significantly lower than those of White faculty).

22. Bhagwan Satiani et al., *A Review of Trends in Attrition Rates for Surgical Faculty: A Case for a Sustainable Retention Strategy to Cope with Demographic and Economic Realities*, J. Am. C. Surgeons, online edition, (Mar. 21, 2013), available at http://www.sciencedirect.com/science/article/pii/S1072751513000860 (finding that non-white faculty left academic medicine at a higher

that discrimination—and limited opportunities for advancement resulting from discrimination—lead minority faculty to consider leaving their institutions or academic medicine in general sooner than whites. *See, e.g.*, Anita Palepu et al., *Specialty Choices, Compensation, and Career Satisfaction of Underrepresented Minority Faculty in Academic Medicine*, 75 Acad. Med. 157, 160 (2000) (adjusting for rank, compensation, department, and professional time allocation, under-represented minority faculty are more likely to leave medicine); Association of American Medical Colleges, *2008 Diversity Research Forum*: *The Importance and Benefits of Diverse Faculty in Academic Medicine: Implications for Recruitment, Retention and Promotion*, at 10-11 (2009) (comprehensive study finding that the institutional climate of racial and ethnic discrimination was one of the top reasons faculty contemplated departure), *available at* https://members.aamc.org/eweb/upload/The%20Diversity%20Research%20Forum%20The%20Importance%20and%20Benefits%20of%20Diverse%20Fac%20in%20Acad%20Med.pdf. One study found that half of surveyed minority faculty members were considering leaving their respective institutions within three years due to concerns about career advancement or an institutional climate of racial or ethnic discrimination. *Id*. at 11. The AAMC and

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rate than white faculty); Hisashi Yamagata, American Association of Medical Colleges, *Trends in Faculty Attrition at US Medical Schools, 1980-1999*, at 1-2 (2002); National Academy of Science, *Beyond Bias and Barriers: Fulfilling the Potential of Women in Academic Science and Engineering* 92 (2006) ("Across all fields of science and engineering women are 40% more likely than men to exit the tenure track for an adjunct academic position ($p=0.01$). In addition to sex, the factors with the strongest correlation to this outcome were race or ethnicity, and employment at a private university or medical school.").

medical researchers have linked the lower representation and promotion rates of minority professors to barriers resulting from decades of systematic segregation and discrimination, as well as cultural and other factors in academic medicine that isolate minority faculty. Marc Nivet et al., *Diversity in Academic Medicine No. 1 Case for Minority Faculty Development Today,* 75 Mt. Sinai J. Med. 491, 494 (2008); AAMC, *Striving*, *supra*, at 7.

As discussed above, minority and female physicians and faculty members in academic medicine often do not report the discrimination they experience given the culture of silence in medicine, poor responses to complaints, and fear of adverse career consequences.[23] They are faced, then, with a choice between living with that discrimination or leaving their jobs. The greater rate at which minority doctors leave teaching as compared to white doctors suggests that many choose the latter. However, this choice is not without consequences to patients. As *amici* will now discuss in more detail, losing talented teachers, caregivers, and researchers due to workplace discrimination has a profound negative effect on public health by harming medical education

23. Phyllis L. Carr et al., *A "Ton of Feathers": Gender Discrimination in Academic Medical Careers and How to Manage It*, 12 J. Women's Health 1009, 1015 (2003) ("It is perceived that those who fight the system [and report discrimination] formally suffer severe consequences. The other option rather than confronting the issue or suing is going to another institution."). As one study reported, minority faculty members considering whether to report racial discrimination have to weigh with the potential loss of peer credibility and respect, as well as a drain on personal time and energy. Megan R. Mahoney et al., *Minority Faculty Voices on Diversity in Academic Medicine: Perspectives from One School*, 83 Acad. Med. 781, 783 (2008).

and, ultimately, the ability of the medical profession to effectively meet the needs of the public it serves.

Minority faculty play important roles in all medical students' professional development as well as in increasing the number of minority students entering the medical profession. As the AAMC has recognized, future doctors will serve an increasingly multicultural community, and must be culturally competent "[i]n order to provide optimal care." AAMC, *Striving*, *supra*, at 6. Further, the presence of minority faculty in academic medicine can increase the number of minority students entering and remaining in medical school and can create a more supportive environment for those students. *See* Disadvantaged Minority Health Improvement Act of 1990, Pub. L. 101-527, § 1(b)(11), 104 Stat. 2312 (1990) (diverse faculty "an important factor in attracting minorities to pursue a career in the health professions"); AAMC, *Striving*, *supra*, at 6 (diverse faculty provide "support to racial and ethnic minority students in the form of academic guidance, mentorship and role modeling").

The role of minority faculty in supporting retention of minority medical students is particularly important because numerous studies have shown that those students are more likely than their white counterparts to go on to provide medical services to high-risk, underserved communities. *See* Price et al., *supra*, at 2 ("Ethnic minority physicians are more likely to practice in underserved areas and to care for patients of their own race/ethnic group, as well as low-income patients, Medicaid-insured and uninsured patients, and patients with poorer health status."); Joseph R. Betancourt et al., *Defining Cultural Competence: A Practical Framework for Addressing Race/Ethnic Disparities in Health and Health Care*, 118

Pub. Health Rep. 293, 296 (2003) ("minority professionals are more likely than their white counterparts to organize health care delivery systems to meet the needs of minority populations"). Further, "[e]thnic minority patients have been shown to experience higher levels of participation and satisfaction with ethnic minority physicians." Price et al., *supra*, at 2; *see also* Betancourt, *supra*, at 296 ("racial concordance between patient and physician is associated with greater patient satisfaction and higher self-rated quality of care").

Finally, the presence of minority faculty in academic medicine enhances research addressing the public health needs of minority communities and accelerate advances in medical and public health research more generally. Minority faculty often provide leadership in research related to racial health inequities and are more likely to engage in research addressing the needs of minority communities.[24] Nunez-Smith et al., *Institutional Variation*, *supra*, at 852; AAMC, *Striving*, *supra*, at 4 ("greater diversity will help ensure a more

24. Racial disparities in incidence of certain serious diseases underscore the importance of this research. It is well-documented that "[s]ignificant health disparities exist along lines of socio-economic status, urban or rural residence and, most notably, race and ethnicity." Bruce G. Link, *Epidemiological Sociology and the Social Shaping of Population Health*, 49 J. Health & Soc. Behav. 367 (2008). Minority populations continue to disproportionately suffer from numerous health conditions. *See, e.g.*, Centers for Disease Control and Prevention, *CDC Health Disparities and Inequalities Report - United States* (2011), *available at* www.cdc.gov/mmrwr/pdf/other/su6001.pdf (illustrating increased rates of maternal death in minority populations based on quality of and access to medical care, socioeconomic conditions, and public health practices).

comprehensive research agenda"); National Institutes of Health, *Draft Report of the Advisory Committee to the Director Working Group on Diversity in the Biomedical Research Workforce* at 11 (2012), *available at* http://acd.od.nih.gov/Diversity%20in%20the%20Biomedical%20Research%20Workforce%20Report.pdf ("full power of diversity to pursue biomedical and behavioral research problems that address the needs of underrepresented racial and ethnic minorities is an important component of reducing these health inequities"). Further, medical research is enhanced when conducted by individuals with diverse views, whether that research involves issues that impact minority communities or not. *See NIH Draft Report*, *supra*, at 11 (studies show that "[d]iverse teams working together and capitalizing on individuality and distinct perspectives outperform homogenous teams"). Conversely, an atmosphere of discrimination undermines productive research: effective research environments depend on a "positive group climate and sufficient diversity of the group." Carole Bland & Mark Ruffin IV, *Characteristics of a Productive Research Environment: Literature Review*, 67 Acad. Med. 385 (1992) [hereinafter *NIH Draft Report*].

Thus, the presence of minority faculty in academic medicine is an essential component of meeting the public health care needs of diverse communities. Minority faculty foster the development of cultural competence in all future doctors and help create a supportive environment for minority medical students, who in turn are likely to practice in underserved communities. Additionally, they can enhance research, particularly affecting minority communities.

Nonetheless, the AAMC and researchers have observed that the recruitment and retention of minority faculty is often infected by bias, discrimination, and associated barriers for minorities in academic medicine. One study concluded that "valuable attributes and abilities [of minority faculty], instead of being perceived and received as beneficial, are often responded to as untoward contributions and become barriers to acceptance in the systems of academic medicine." Pololi et al., *supra*, at 1367. In addition, once hired, minority faculty often felt "isolation" and "experienced disrespect, discrimination, racism and a devaluing of their professional interests," in addition to facing lower rates of promotion in academic medicine. *Id.* These dynamics make Title VII protections more critical: absent adequate protection from retaliation, minority faculty could be further silenced, leading to greater dissastisfaction and attrition.

With Dr. Nassar's departure, UTSW lost a highly regarded teacher who instructed students, residents, and fellows on HIV treatment. JA 340-41. UTSW, Parkland, and Parkland's HIV patients lost an excellent diagnostic clinician who rated in the ninetieth percentile among all subspecialties in internal medicine at UTSW. JA 341. His departure compromised the care received by HIV patients at Parkland, which was unable to hire a replacement for over six months, and which even then hired a doctor insufficiently trained in HIV care. JA 65-66. UTSW lost a talented researcher who ran clinical trials, presented at national and international conferences, and published studies in peer-reviewed journals. JA 342-43. As the Association of American Medical Colleges

recognized in making its case for the benefits of diversity, "public health is at stake, not just business interests."[25] Discrimination in medical schools interferes with the goal of diversifying medical school administration, faculty, and students, and harms public health by negatively affecting training, provision of care, and advancement of medical and scientific knowledge. Insufficient safeguards against retaliation compound this harm, resulting in silence and exit of talented teachers, caregivers, and researchers, including Dr. Nassar.

CONCLUSION

For the foregoing reasons, this Court should affirm the judgment of the Fifth Circuit Court of Appeals.

Respectfully submitted,

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25. *AAMC Fisher Br.*, *supra*, at 13