Defending Diversity: Affirmative Action and Medical Education

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ABSTRACT

Affirmative action programs of all types are under attack legally and politically. Although medical schools have not been specifically targeted, their affirmative action programs, like others in higher education, are potentially in danger. This article examines the current legal status of affirmative action in medical education and concludes that a refurbished defense of such programs is essential if they are to survive impending judicial and political scrutiny. An analysis of existing case law and available evidence suggests that a carefully reinvigorated diversity argument is the tactic most likely to pass constitutional muster, as well as the justification most likely to blunt growing public and political opposition to admissions policies that take race and ethnicity into consideration. (*Am J Public Health*. 1999; 89:1256–1261)

Affirmative action in higher education is in peril—judicially, politically, and in the court of public opinion. A series of federal court decisions have cast a constitutional pall over many of the nation's affirmative action policies. In 1992, rejected applicants—asking for both injunctive relief and monetary damages—sued the University of Texas School of Law and its dean, claiming that the school's admissions policies constituted illegal reverse discrimination. In 1997, nearly identical suits against the University of Washington and the University of Michigan were filed by lawyers from the Center for Individual Rights, an organization that has emerged to provide legal aid to individuals who feel they have been wronged by affirmative action policies. In November 1998, the First Circuit Court of Appeals, in *Wessmann v Gittens,* invalidated the prestigious Boston Latin School's affirmative action policy, even though a judicial order had once been required to ensure the school's desegregation.[1] More suits are planned, and according to one anti–affirmative action attorney involved in the litigation, "It's like shooting fish in a barrel."[2]

Affirmative action is under attack in the political arena, too. California spearheaded the movement in 1996 with Proposition 209, a voter-mandated prohibition on the use of race-based affirmative action policies by government entities. Washington State followed with Initiative 200 in November 1998. In addition, legislators in more than a dozen states have introduced anti–affirmative action bills in the last 2 years. This increasing judicial and political activity reflects a decreasing popular commitment to broad-based affirmative action policies.[3] A 1997 Washington Post–ABC News survey found that "only one in six whites but nearly half of all blacks believe that minorities should receive preference in college admissions."[4] Given the current social and political climate, medical schools may soon be called upon to defend their commitments to racial balance through admissions practices. Although there are a number of complementary grounds on which to defend affirmative action, the most tenable will be a revitalized articulation of the importance of diversity in medical practice and education.

Affirmative Action and the Law

Any law or action by any state entity must meet the requirements of the Fourteenth Amendment of the Constitution, which holds that "no state shall . . . deny to any person within its jurisdiction the equal protection of the laws." Governmental actions that take race into account are deemed inherently "suspect" under Fourteenth Amendment jurisprudence. Race has been designated a "suspect" classification by the courts because one of the chief purposes of the Fourteenth Amendment is to eliminate long-standing official, state-based discrimination against African Americans; because de jure discrimination based on race has traditionally been seen to connote inferiority; and because victims of racial discrimination by the state are sometimes less able than other victims of discrimination to seek relief through the political and electoral system and thus warrant special judicial protection. As a result, state actions involving classification, differentiation, or discrimination based on race must meet an especially heavy burden—the "strict scrutiny test" (e.g., see references 5–8).

Under the strict scrutiny test, a state classification based on race is presumed to be unconstitutional unless the state entity can show that the classification is necessary to

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further a "compelling state interest." The state must also show that the state action in question is narrowly tailored to meet that compelling state interest. A court will weigh the efficacy of alternative remedies, the flexibility and duration of the policy, the relationship between the program's numerical goals and the percentage of minorities in the relevant population, and the impact of the program on the rights of innocent third parties.[8] Under the strict scrutiny test, state legislation that discriminates against minorities has invariably been declared invalid.[5–7]

Some scholars and judges endorse a lower level of constitutional scrutiny—the "intermediate level of scrutiny"[9,10]—when the state action represents an attempt to benefit minorities. They argue that the original purposes of the Fourteenth Amendment and the historical experience of racial minorities justify special protection for these groups. If such a standard were adopted by the federal courts, programs designed to benefit racial minorities would be easier to defend than those that work to the detriment of racial minorities.

The current judicial trend,[11,12] however, reflected in the Supreme Court's decisions in *Richmond v Croson* (1989)[13] and *Adarand Constructors, Inc v Pena* (1995),[14] has been to apply the strict scrutiny test to state action that is friendly to minorities, such as affirmative action, in the same way that it is applied to state action that is hostile to minorities. Observers who support the use of the strict scrutiny test for any state action that uses race as a factor assert that it is impossible to advantage one race without disadvantaging the less favored races. Unadulterated equality before the law, they argue, should be the benchmark of state action; otherwise the constitutional protections embodied in the equal protection clause would be subject to the ebb and flow of temporal political sentiment.

A change of court personnel or the evolution of jurisprudence may diminish the importance of the strict scrutiny test in evaluating state action,[15] but in the short term at least, strict scrutiny is the measure that must be met by medical schools and other state entities that use race to help choose students.[16]

Meeting the Current Legal Standard

Admissions policies that establish quotas or set-asides will not pass constitutional scrutiny. These policies have been prohibited since the *Bakke* case[17] and are now rare or nonexistent. (Alan Bakke, a White man, challenged the affirmative action policy of the University of California–Davis School of Medicine. Justice Lewis Powell joined with 4 other justices to hold that race-based numerical quotas violate both the equal protection clause of the Fourteenth Amendment and the Civil Rights Act of 1964. Thus Bakke must be admitted. However, Powell also joined with other justices to conclude that race, in some situations, might legitimately be considered as long as admission was not based solely on that factor.) The absence of quotas, however, does not guarantee that a particular policy or practice will be affirmed; neither does the claim that race is only one of a totality of factors that influence admissions decisions. *Bakke* states that race may be used as a "plus factor" in admissions considerations, but if that plus factor is determinative in individual cases it must still face the strict scrutiny test.

Disappointed nonminority applicants or activist opponents of affirmative action might attempt to demonstrate that race is being used as a determining factor by gaining access to an institution's application files, either through the discovery process, in the event that litigation has been initiated, or through the relevant state's open records or freedom of information acts (e.g., see references 18–22). Applicants' race, grade-point averages, standardized test scores, and residency can be evaluated by means of such statistical techniques as logistic regression and discriminant analysis to discover whether race plays a determining role in the institution's decisions to admit students. The policy or practice that is shown to use race as a determining factor will be presumed to be unconstitutional unless the institution demonstrates (1) that the policy or practice is motivated by a "compelling state interest" and (2) that it is narrowly tailored to achieve that state interest.[16]

Remedying the Effects of Past and Current Discrimination

Courts have acknowledged that affirmative action programs may satisfy the compelling state interest requirement if they are intended to remedy the continuing effects of past and present discrimination. But although African Americans and other minorities have suffered tragically from discriminatory practices in this country, medical schools may find it difficult to justify affirmative action policies on these grounds. Courts have consistently held that a desire to correct the effects of general "societal discrimination" is not a compelling state interest sufficient to justify the strict scrutiny test.[13,23] To show a compelling state interest, the state must identify specific discrimination by a governmental entity.

Courts may allow medical schools to demonstrate that their policies are intended to remedy the continuing effects of past discrimination in grades kindergarten through 12 of the relevant state's public education system. But this approach, too, may pose difficulties to medical schools defending challenged affirmative action practices. Many medical schools, relying on *Bakke,* established their policies years ago and did not base their affirmative action programs explicitly on attempts to remedy past discrimination.[16,24,25] Therefore, it is unlikely that medical school or state policymakers will possess evidence that demonstrates the continuing effects of discrimination throughout the relevant state's public school system; they never saw the need to collect it.[26]

Providing courts with evidence of discrimination against the cohort of students currently applying for admission to medical schools may also be difficult. Many of those students entered the public school system in the early 1970s, a period marked by mandatory desegregation through busing and by relatively aggressive civil rights enforcement policies with regard to public school enrollment.[27] As a result, although racism and discrimination still limit the opportunities of minorities in very real ways, it may be difficult to generate evidence of the sort of systemic discrimination in a public school system that requires a remedy at the level of professional education. Even if such evidence were collected, it is not clear that courts would accept it to justify a policy retrospectively.[28(p67)]

These evidentiary hurdles, combined with the now relatively consistent application of the strict scrutiny test by the Supreme Court and federal circuit courts, may undermine a medical school's defense of race-based affirmative action practice on the basis of the continuing effects of discrimination. Consequently, although the concept of diversity in medical school education is in jeopardy, it may ultimately provide the most valuable and practical legal defense of affirmative action in medical education.

The Courts and Diversity

One of the earliest and fullest examinations of the diversity justification appeared in *Bakke* in 1978. In *Bakke*, Justice Lewis Powell explained that the medical school's desire to create a diverse student body to provide more physicians for underserved minority populations did not constitute a compelling state interest. Powell noted that there was insufficient evidence in the record that the medical school's special admissions program was needed or that it was likely to promote

the stated goal of the program. However, he offered another reason why the pursuit of diversity might satisfy the compelling state interest test. Diversity, he asserted, is vital for the "robust exchange of ideas." Thus, according to Powell, the selection of diverse students who would contribute to an intellectually vibrant academic community was a constitutionally permissible goal.[17(pp310–315),23] The constitutional meaning of diversity in higher education has never again been analyzed in a Supreme Court majority opinion.

This paucity of judicial analysis and precedent has endangered the diversity justification as challenges to affirmative action programs became more common.[15] The diversity justification was attacked directly in *Taxman v Board of Education of Piscataway* (1996)[29] and *Hopwood v Texas* (1996).[12] In *Hopwood,* the Fifth Circuit Court applied the strict scrutiny test to the University of Texas law school's affirmative action policies and emphasized that Powell's elevation of diversity as a compelling state interest in Bakke was never joined by the majority of the court. As a result, according to the *Hopwood* court, Powell's swing-vote opinion in *Bakke* did not represent the position of the Supreme Court or the law of the land.[12(pp941–944)] In short, diversity in higher education did not represent a compelling state interest. *Hopwood* has binding legal force only in the Fifth Circuit (Texas, Louisiana, and Mississippi), but many observers, including the dissenters, have warned that the "radical implications of this opinion, with its sweeping dicta, will literally change the face of public educational institutions throughout Texas, the other states of this circuit, and this nation."[30] Even if the *Hopwood* ruling is ultimately deemed a mistaken reading of the Supreme Court's position, the diversity rationale clearly needs rejuvenation.[31]

The Case of Private Medical Schools

Most of the leading affirmative action education cases have involved state rather than private institutions. Consequently, it is a matter of some speculation whether the foregoing discussion applies with equal force to private medical schools that attempt to implement affirmative action programs. The equal protection clause of the Fourteenth Amendment applies to state action. Title VI of the Civil Rights Act of 1964[32] prohibits discrimination by private entities that receive federal funds. Although there is no definitive case law specifically relating to affirmative action programs at private educational institutions that receive some manner of federal funds, courts have held that the test for purported Title VI violations is the same as that applied under the equal protection clause of the Fourteenth Amendment.

Significantly, benchmark cases such as *Bakke* and *Hopwood* were brought under both Title VI and Fourteenth Amendment claims. Private institutions in the jurisdiction covered by *Hopwood* have assumed that the case's mandate applies to them as well as their public counterparts.[33(p182)] Thus, according to Christopher Edley, who reviewed national affirmative action policies for the Clinton administration, "it is reasonable to expect that after *Croson* and *Adarand* the question will be whether the [private] entity has a compelling interest and whether the affirmative action measure is narrowly tailored."[28(p69)] There are potential arguments to be made that Title VI challenges might and should be viewed differently from Fourteenth Amendment claims. But for now, it is likely that the same strict scrutiny test will be applied to private and state educational institutions that attempt to enact affirmative action admissions policies.

Defending Diversity

The constitutional argument in favor of diversity as a "compelling state interest" in medical schools may be imperiled, but it is not moribund. There is scattered support for the doctrine in a number of Supreme Court rulings. Although the observation was not a part of its holding, the Supreme Court majority in *Metro Broadcasting, Inc v FCC* observed that "a diverse student body contributing to a robust exchange of ideas is a constitutionally permissible goal on which a race-conscious university admissions program may be predicated."[34] Justice Sandra Day O'Connor, in a concurring opinion in *Wygant v Jackson Board of Education,* noted that "a state interest in the promotion of racial diversity has been found sufficiently 'compelling' at least in the context of higher education, to support the use of racial considerations in furthering that interest."[23(p286)] No federal court, including the *Hopwood* court, has ever stated unequivocally that diversity can never be considered a compelling state interest. Instead, courts have held that the goal of diversity as articulated in particular factual contexts is not compelling, or that insufficient evidence has been marshaled to demonstrate its compelling character. Thus, diversity may still represent a compelling state interest if it is properly explained and supported by the relevant legislature or governmental entity.

In medical education, the special nature of the doctor–patient relationship, society's growing understanding of the complexity of race relations in the United States, and the quantitative and qualitative evidence that has become available in the last 20 years may help make the case that diversity is a constitutionally legitimate motive for enacting an affirmative action program. There are 3 related grounds on which diversity might be considered a "compelling state interest" in medical education: (1) that it will increase the number of physicians who serve traditionally underserved patients and specialty areas, (2) that it promotes the robust exchange of ideas in medical education, and (3) that it will result in better medical care for minority patients.

Increasing the Number of Physicians in Underserved Areas and Practice Specialties

There is now some empirical evidence highlighting the potential role of minority physicians in increasing the health status of the nation, which was not the case at the time of *Bakke.* Komaromy et al. recently found that African American and Hispanic physicians cared for a larger percentage of minority patients than did their White counterparts and that they were more likely to practice in communities with insufficient numbers of primary care practitioners and to care for Medicaid patients and uninsured patients.[35] Similarly, in 1993, the American Association of Medical Colleges reported that 39.8% of medical school graduates from underrepresented minorities reported that they intended to practice in underserved areas, compared with only 9% of other graduates.[36]

These studies and others[37–40] constitute a growing body of evidence that minority physicians may play an important role in advancing the overall health of the nation's citizens. These data could be augmented with statistics generated at individual medical schools that track the career paths of their minority physician graduates. For both economic and humanitarian reasons, states and state entities have a compelling interest in furthering the health of their citizens. Therefore, with sufficient documentation, a medical school might be able to contend successfully that affirmative action programs that place more minority physicians in the medical workforce serve a compelling state interest.

It is possible, though, that individual courts will not view the available empirical evidence, some of which is equivocal, as sufficient. Even if a court agrees that increasing the number of minority physicians serves the compelling state interest of improving the health of underserved populations, the means devised to achieve that compelling state interest must be "narrowly tailored" to further that end.

For example, a medical school that defends an admissions policy on the grounds that more physicians are needed for underserved populations might also have to demonstrate that no alternative race-neutral means of reaching that end are available.

A defense of diversity on the grounds that minority physicians are more likely to bring primary care to underserved populations is precarious on other grounds. Many minority medical students do wish to practice in underserved areas as primary care physicians. Some, however, want to practice medicine in non–primary care specialties and in areas of the country that are not underserved. Society should be wary of any policy that suggests that minority physicians should be directed into any particular geographic area, type of neighborhood, or medical specialty. Such observations do not mean that diversity-based policies cannot be justified on the grounds of providing primary care to underserved populations, but the vulnerability of this argument should encourage supporters of affirmative action programs to seek out supplemental reasons why diversity is a compelling state interest.

The Robust Exchange of Ideas

Supporters of the diversity justification for affirmative action might also consider rejuvenating Powell's assertion in *Bakke* that diversity is a compelling state interest because it helps students develop more sophisticated interpersonal skills by forcing them to interact with people of different perspectives.[17] Federal courts have acknowledged the utility of diversity in law enforcement agencies that are responsible for working with diverse populations (for example, see reference 41). Similarly, a critical mass of minority medical students may provide their nonminority colleagues with insights into the racially and culturally based concerns of future patients. Daily contact with students of different backgrounds—contact that includes discussions about the clinical, social, and ethical aspects of patient care—may help nonminority physicians serve the needs of their minority patients in the future.

The goal of better patient care represents a justification that is far more constitutionally compelling than mere intellectual enrichment for medical students. But in a political and jurisprudential environment that is increasingly suspicious of race-based remedies, it is important to possess evidence that diversity actually helps to achieve this goal. Such evidence may be elusive. Moreover, even if a court finds that a diverse educational environment leads to better patient care by sensitizing nonminority students, the medical school will be asked to demonstrate that the race-conscious policy is narrowly tailored to achieve that goal. For example, has the medical school considered other, race-neutral, means of awakening its nonminority students to the concerns and needs of their future patients who may be minorities? Would workshops, discussion groups, speakers, or the use of standardized patients be equally effective in preparing nonminority physicians to care for diverse patient populations? (See, for example, Lum and Korenman.[42])

Better Patient Care: The Most Compelling State Interest

Diversity in the medical profession is a compelling state interest because only it can ensure that minority populations will receive adequate health care. The state has not only an interest in producing but a duty to produce physicians who can engage in therapeutic relationships with their patients that are based on mutual trust—a requirement for optimum delivery of health services. The historical experience of minority groups, especially African Americans, with the medical profession is very different from the experience of nonminorities, and as a result they view encounters with medical professionals in a fundamentally different way than do nonminority patients.

Annette Dula has argued that "[f]rom slavery times to the present, US descendants of Africa have harbored a justified mistrust of medicine and medical research [that] cannot be simply written off as paranoia or hypersensitivity."[43(p347)] This distrust has its origins in antebellum slave culture, in which White physicians were viewed as owing allegiance to the slave owner rather than to the slaves who were their patients.[44,45] The ambivalent relationship between organized medicine and African Americans continued after emancipation. The medical profession played a role in developing late 19th-century racial theories insinuating that Blacks were physiologically different from and evolutionarily inferior to Whites.[46,47] This view of African American biology and physiology helped inspire the now infamous Tuskegee Syphilis Study, in which medical research was conducted on Black men without their consent and they were denied access to beneficial treatment.[48] The role of researchers' exploitation and mistreatment in helping to shape the African American view of the medical establishment can hardly be overstressed.[49] At the same time, throughout the first half of the 20th century medical institutions and the medical profession implicitly and explicitly supported a segregated medical delivery system that typically provided African Americans with separate and unequal care.[50–52]

The medical slights and harms born of racism have not been forgotten in the post-segregation world. According to historian Vanessa Northington Gamble, "there is a collective memory among African Americans about their exploitation by the medical establishment."[49(p1775)] The distrust generated by this legacy can endanger the doctor–patient relationship and the comfort level African American patients feel with nonminority physicians. A number of studies have demonstrated that minorities clearly prefer to be treated by physicians drawn from their own ethnic groups.[53]

Minorities' distrust of the medical profession is rooted also in their perception of the contemporary health care system. There is growing and credible evidence that health professionals continue to treat minorities differently from nonminorities in ways that undermine their health status.[54] One study found that primary care physicians who care for predominantly minority patients "were less likely to follow guidelines from nationally recognized organizations for health promotion and disease prevention" than were physicians who care for predominantly White patients.[55] Another found that the rates for ambulatory care visits, mammography, and immunizations were lower for Black patients than for Whites at every income level. Other research reveals lower utilization rates for African Americans for ordinary components of basic medical care, such as laboratory tests and x-rays.[56]

African American patients are more likely than White patients to report that their physicians did not express concern for their pain and failed to provide them full information about their examination findings, test results, diagnoses, medications, and prenatal care.[57,58] In one study, race was associated with less timely follow-up by physicians after an abnormal screening mammogram.[59] Other studies have found that African Americans are more likely than Whites to be hospitalized for avoidable conditions[60] and that, once hospitalized, they may receive a lower quality of care and be less stable at discharge than other patients.[56,61] African American patients are less likely than White patients to receive hip and knee replacements,[62,63] to receive antiretroviral therapy or prophylaxis for *Pneumocystis carinii* pneumonia on first referral to an HIV clinic,[64] and to undergo surgical resection for colorectal cancer (this difference was found even after researchers controlled for age, comorbidity, and extent and location of tumor).[65]

African Americans, regardless of income level, are more likely than White patients to

undergo procedures such as lower-limb amputation, bilateral orchiectomy, and cesarean delivery.[66] The authors of one study concluded that their findings "suggest inappropriate influences on clinical decision making that would not be addressed by changes in reimbursement."[67] Racial variations in cardiac care have been the most well documented. Even studies that control for disease severity, economic and insurance status, and the presence of comorbid conditions find that Blacks receive less intensive cardiac care.[68–74] In the November 1997 issue of the Journal, H. Jack Geiger mentioned an ongoing study that suggests that the treatment disparities in cardiac care cannot be attributed to patient preference, "raising the probability that the differentials are the result, instead, of covert or unconscious racial stereotyping by physicians in their assessment of patients' suitability for such procedures."[54(p1766)]

Physicians are less effective at treating patients who do not trust them. And it is increasingly evident that African Americans and other minority patients have strong grounds for doubting both the goodwill and the color blindness of White medical practitioners. The empirical evidence suggesting differential medical treatment of minorities, the suspicion based on historical experience, and anecdotal accounts from minority patients combine to undermine the relationship between White physicians and minority patients, despite individual physicians' goodwill and regardless of whether the minority patient's fears are correct in any individual case. For example, African Americans are the patient group most likely to distrust the care they will receive at the end of life.[75] By influencing such factors as patterns of compliance, preventive care, and patient disclosure of information and choice of therapies,[43] such distrust can have a substantial impact on the care that minority patients receive. This suspicion is so deep-seated and widespread that, in the short term, the only remedy is to provide minority patients with physicians with whom they feel safe and comfortable.[76]

This justification for race-conscious admissions policies does not represent an attempt to remedy past wrongs or to help aspiring medical students from disadvantaged backgrounds (although it may incidentally do both). Instead, it is based on the state's utilitarian interest in ensuring that medical professionals can do their job. It does not require evidence of past discrimination against minority medical school applicants and evidence of the current ill effects of those wrongs. It does not require a link between the victims of discrimination and the recipients of preferential treatment. All it requires is convincing evidence that African Americans and other minorities have persistent and deep fears that the color of their skin will affect the care they receive from their doctors and that those fears undermine the therapeutic alliance that should characterize the doctor–patient relationship. Some such evidence already exists, and more can be collected both nationally and locally through continuing studies of the way in which minorities and the health care system interact. This evidence might be marshaled to convince courts considering the constitutionality of a medical school's admissions policy that better health care is a compelling state interest and that a racially diverse physician workforce is the only effective means of satisfying that interest.

Conclusion

Even if the courts accept this argument—and it is by no means certain that they will—affirmative action supporters must still win the political and public relations campaign. Otherwise, even judicially sanctioned affirmative action practices could be struck down by legislative fiat or popular referendum. The outcome of the political debate will depend on how successfully supporters can articulate the moral and social reasons why affirmative action is justified, irrespective of its constitutionality. Affirmative action policies might be justified morally and politically as a form of compensatory justice, a repayment of the debt owed to groups of individuals that have been wronged. They might also be rationalized as a form of distributive justice, a way of ensuring that individuals from disadvantaged groups receive a just distribution of society's goods and opportunities. Compensatory and distributive justice arguments are cogent and sufficiently strong to convince some people of the need for affirmative action remedies.[77,78]

Politics, however, is the art of the possible. In the realm of political debate and moral argument, a diversity-based utilitarian goal is likely to garner more public support than other justifications and thus will be most helpful in answering and forestalling further political attacks on affirmative action. It does not raise the contentious issues of blame and debt. Instead, the diversity justification for affirmative action rests on the more modest, but demonstrable, claim that society has an interest in providing adequate care to patients. The medical profession and the health care system will have to win the trust of the minority community before they can deliver health care in an effective manner. For now, this trust can be won only by substantially increasing the number of minority physicians available for minority patients. □

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