2008

A Prescription for Racial Equality in Medicine

Barbara A. Noah
Western New England University School of Law, bnoah@law.wne.edu

CONNECTICUT
LAW REVIEW

VOLUME 40 FEBRUARY 2008 NUMBER 3

Article

A Prescription for Racial Equality in Medicine

BARBARA A. NOAH

A significant body of evidence suggests that minority race adversely affects the quantity and quality of health care provided to minority patients. Although no one has documented systemic overt racism among health care providers, persistent inequities in the delivery of health care services pose serious problems for patients of color. Ultimately, the medical establishment must confront the reality that African Americans and other racial minorities often do not receive equal treatment in the health care system.

The continued implementation of affirmative action programs as part of the medical school admissions process plays a key role in improving health care delivery for patients of all races. Diversity in the medical school classroom guarantees diversity in the physician workforce. This in turn increases access to care for underserved patients and provides many patients of color with the opportunity to receive care from a physician with whom they can communicate effectively and whom they trust. Ideally, diversity in medical education also helps all physicians in training to develop crucial communication skills and to break down racial, cultural, and religious stereotypes so that all medical school graduates will be equipped to communicate with and provide optimal care for patients whose race or background differs from their own.

For now, race-conscious admissions policies play an essential role in guaranteeing racial and ethnic diversity in medical schools and in improving the odds that medical schools will graduate "culturally competent" physicians. These combined circumstances suggest that the grounds for maintaining programs of affirmative action in medical school admissions are perhaps more compelling than in many other higher education contexts. The Supreme Court's conclusion in Grutter *that racial diversity in the classroom represents a compelling governmental interest serves as an important step towards achieving racial justice in health care because it gives medical schools permission to take carefully considered affirmative steps to admit diverse classes of qualified students. Nevertheless, affirmative action in higher education remains constitutionally and socially controversial and universities utilizing race-conscious admissions policies should not become complacent. Medical schools should be prepared to consider alternative strategies to achieving diversity and simultaneously should take a hard look at curriculum choices in order to maximize the impact of medical education for the patients they serve.*

ARTICLE CONTENTS

A Prescription for Racial Equality in Medicine

BARBARA A. NOAH*

The man who never alters his opinion is like standing water, & breeds reptiles of the mind.

William Blake
THE MARRIAGE OF HEAVEN AND HELL
Plate 19 (1790)

I. INTRODUCTION

Statistically, race plays a profound role in health. Estimates suggest that by 2030, well over forty percent of the American population will be members of minority races.[1] A recent Harvard study examining regional and nationwide disparities in life expectancy found an eighteen year gap between the life expectancy for Asian females compared with African American males.[2] Although the causes of such dramatic differences in life expectancy are multiple and complex, evidence suggests that cultural

---

* Associate Professor, Western New England College School of Law; J.D. Harvard Law School. This project was supported by a research grant from Western New England College School of Law. Thanks to Jamie Colburn, Réné Reich-Graefe, and Katharine Van Tassel for their helpful comments and suggestions and to Natalie Jones for her research assistance.

[1] *See* U.S. Bureau of Census, *Projected Population of the United States by Race and Hispanic Origin: 2000 to 2050*, tbl.1a (2004), *available at* http://www.census.gov/ipc/www/usinterimproj/ (estimating that 44.3 percent of the total U.S population will be Black, Asian, Hispanic, or of other non-white race). In addition to race, some new research clearly demonstrates that class independently influences health, although it is sometimes difficult to separate out the individual effects of race versus class. *See* Stephen L. Isaacs & Steven A. Schroeder, *Class—The Ignored Determinant of the Nation's Health*, 351 NEW ENG. J. MED. 1137, 1137 (2004) (observing that "[p]eople in upper classes—those who have a good education, hold high-paying jobs, and live in comfortable neighborhoods—live longer and healthier lives than do people in lower classes, many of whom are black or members of ethnic minorities. And the gap is widening"); *see also id.* at 1138–39 (surveying evidence on relationships between income and types of employment and odds ratio for death from all causes and concluding that socioeconomic status differences contribute substantially to differential death rates between African Americans and whites).

[2] *See* Christopher J. L. Murray et al., *Eight Americas: Investigating Mortality Disparities Across Races, Counties, and Race-Counties in the United States*, 3 PLOS MED. 1513, 1514 (2006) (finding that, in 2001, Asian females in the United States had an overall life expectancy of 86.7 years, compared with 68.7 years for black males); *see also* Richard Perez-Pena, *Harvard Study Reveals That Bergen County, N.J., is Long in Longevity*, N.Y. TIMES, Sept. 12, 2006, at B4, *available at* LEXIS, News Library, NYT File (noting that Asian-American women in Bergen County have the longest average lifespan, ninety-one years, of any racial group in the nation). Moreover, African Americans bear a disproportionate burden of certain diseases, including stroke, perinatal disease, certain cancers, and diabetes. *See* Centers for Disease Control and Prevention, *Health Disparities Experienced by Black or African Americans—United States*, 293 J. AM. MED. ASS'N 922, 922 (2005).

barriers to doctor-patient communication and resulting disparities in quality of care contribute substantially to the gap.[3] More broadly, a significant body of research demonstrates that race adversely affects the quantity and quality of health care provided to minority patients.[4] In order to tackle this truly odious quality gap, medical educators, individual health care providers, and health care institutions must take active steps to identify its underlying causes and make changes at all levels of health care delivery. This Article focuses primarily on the dynamic between individual provider and patient, and it considers educational and policy mechanisms, consistent with current law, to improve quality of care for patients of color and, ultimately, for all patients.

Research suggests that the quality of communication between physician and patient strongly influences the quality of care that the patient receives, and that social and cultural stereotypes can interfere with communication. Racial and cultural diversity in medical education helps physicians in training to develop crucial communication skills and to break down stereotypes so that all medical school graduates, not only minority physicians, will be equipped to communicate with and provide optimal care for patients whose race differs from their own. The concept of diversity frequently is understood to refer to racial and ethnic diversity, particularly focusing on the inclusion of under-represented minority (URM) groups, but the ideal medical school class should include not only under-represented racial and ethnic minority students, but also students of diverse political viewpoints, religions, and socio-economic backgrounds.

As explained within, diversity in medical education promotes two separate but related goals. First, admitting students of diverse backgrounds obviously opens up the professional field of medicine to members of diverse racial groups. Because URM physicians more often choose to work in medically underserved areas, this in turn increases access to care for underserved patients and provides many patients of color with the opportunity to receive care from a physician with whom they can communicate effectively and whom they trust. Second, diversity in medical education breaks down racial, cultural, and religious stereotypes

---

[3] *See* Murray et al., *supra* note 2, at 1522 (listing opportunities and interventions that could be used to reduce disparities in health care); *see also infra* notes 29–49 and accompanying text.

[4] *See* Louis W. Sullivan, *From the Secretary of Health and Human Services*, 266 J. AM. MED. ASS'N 2674, 2674 (1991) ("I contend that there is clear, demonstrable, undeniable evidence of discrimination and racism in our health care system. For example, each year since 1984, while the health status of the general population has increased, black health status has actually declined."); *see also* David R. Williams et al., *The Concept of Race and Health Status in America*, 109 PUB. HEALTH REP. 26, 26 (1994) (noting that, despite significant medical progress over the course of the twentieth century, African Americans "continue to bear a higher burden of death, disease, and disability"). Although no one has documented systemic overt racism among health care providers, recurrent and persistent inequities in the delivery of health care services pose serious problems for patients of color. *See infra* notes 29–49 and accompanying text (describing racial bias and disparities in care that contribute to health inequalities between population groups).

by exposing all members of the medical school class to the different perspectives and experiences of their classmates. This immersional experience, together with explicit training in "cultural competence," can improve the quality of communication between physicians and patients and, ultimately, the quality of medical care.

Because of longstanding societal inequities, the admission of well-qualified medical students from under-represented minority groups continues to pose challenges and, for now, admissions policies that consider race (among other important factors) play an essential role in guaranteeing racial diversity in medical schools.[5] Other commentators have ably presented and evaluated the now-familiar arguments offered by proponents and critics of affirmative action in higher education.[6] Supporters of affirmative action in higher education argue that these admissions programs both atone for past discrimination and provide some counter-balance for ongoing societal bias, and that diverse classrooms enhance the learning experience for students of all races and prepare graduates for work in a racially and culturally diverse world.[7] Detractors of affirmative action in this context suggest that race-conscious admissions policies draw attention to and perpetuate racial differences, stigmatize the intended beneficiaries of affirmative action, and unfairly exclude highly qualified white applicants.[8] This Article brackets and sets aside the larger, complex debate over affirmative action in higher education and instead focuses on the operation and influence of the diversity rationale as a justification for race-conscious admissions programs and its importance to eliminating bias and improving quality in health care delivery.

After a twenty-five year pause, the Supreme Court in 2003 once again spoke on the issue of affirmative action in higher education admissions and affirmed the ability of public colleges and universities to consider race as a factor in the admissions process. The narrowly drawn opinions in *Gratz v. Bollinger* and *Grutter v. Bollinger* focused on the specific educational contexts in which they arose—*Gratz* on undergraduate admissions and *Grutter* on law school admissions.[9] The *Grutter* opinion considered and endorsed classroom diversity as a compelling governmental interest justifying the use of race and ethnicity as a factor in higher education admissions,[10] as originally suggested by Justice Powell's well-regarded

---

[5] *See infra* Part IV.A (discussing the history of policies).

[6] *See, e.g.*, WILLIAM G. BOWEN & DEREK BOK, THE SHAPE OF THE RIVER: LONG-TERM CONSEQUENCES OF CONSIDERING RACE IN COLLEGE AND UNIVERSITY ADMISSIONS, at xxiv (1998) (arguing for the benefits of affirmative action); *see generally* Charles R. Lawrence, III, *Two Views of the River: A Critique of the Liberal Defense of Affirmative Action*, 101 COLUM. L. REV. 928 (2001) (critiquing some arguments in favor of affirmative action).

[7] BOWEN & BOK, *supra* note 6, at xxiv.

[8] *Id.* at xxiii–iv.

[9] Gratz v. Bollinger, 539 U.S. 244 (2003); Grutter v. Bollinger, 539 U.S. 306 (2003).

[10] *Grutter*, 539 U.S. at 329–32.

opinion in *Regents of the University of California v. Bakke*.[11]

None of these opinions, however, explored in any depth the question of whether the nature of the compelling state interest justifying the consideration of race in higher education admissions differs from one educational context to another. As with many complex societal issues, broad generalizations work less well than specific and nuanced discourse to promote consensus. Because affirmative action and the diversity rationale will continue to provoke controversy, those who engage in the debate should attempt to make the dialogue more productive. Some skeptics view diversity as a visible manifestation of political correctness run amok, with little intrinsic value.[12] Others see multiple layers of benefit, to minority students, their white classmates, and to society at large.[13] Given this divergence of opinion, it would be helpful to explore the value and function of affirmative action to achieve diversity in specific educational contexts rather than simply as a general concept. Accordingly, this Article considers the operation of diversity as a justification for race-conscious medical school admissions and suggests that, although the rationales offered in support of race-conscious admissions support the use of these strategies to diversify classes in all types of higher education, the diversity rationale in medical education is different in kind and, in terms of its ultimate societal impact, arguably more compelling than in other contexts.

The *Grutter* decision by no means settled the debate about affirmative action and the value of diversity in higher education. In fact, a couple of recent developments suggest that this issue will continue to receive attention and that universities utilizing race-conscious admissions policies should not become complacent. With recent changes in the Supreme Court's composition replacing the authors of the majority opinions in both *Gratz* and *Grutter*,[14] it is not inconceivable that the newly-constituted

---

[11] Regents of the Univ. of Cal. v. Bakke, 438 U.S. 265 (1978).

[12] *See, e.g.*, George F. Will, *The Court Returns to Brown*, WASH. POST, July 5, 2007, at A17 *available at* LEXIS, News Library, WPOST File (giving a nod to the Court's decision in *Grutter*, but adding that "diversity preferences appeal to race-obsessed social engineers—a cohort particularly prevalent among today's educators—precisely because . . . [t]he diversity project is forever a work in progress").

[13] *See, e.g.*, Joshua M. Levine, *Stigma's Opening:* Grutter*'s Diversity Interest(s) and the New Calculus for Affirmative Action in Higher Education*, 94 CAL. L. REV. 457, 461–75 (2006) (exploring the several different educational and societal benefits that diversity in higher education can deliver).

[14] Chief Justice John Roberts has replaced Chief Justice Rehnquist, and Justice Samuel A. Alito, Jr. has replaced Justice O'Connor. Justice Anthony M. Kennedy now appears poised to step into Justice O'Connor's role as a centrist casting the swing vote on significant cases. *See* Charles Lane, *Kennedy Reigns Supreme on Court; With O'Connor's Departure, Sole Swing Voter Wields His Moderating Force*, WASH. POST, July 2, 2006, at A06, *available at* LEXIS, News Library, WPOST File. Although Justice Kennedy voted against Michigan's undergraduate and law school affirmative action programs, he did express some support for Justice Powell's approach to evaluating such programs. He acknowledged that a university can properly assert that racial diversity furthers its educational goals, but insisted on "rigorous judicial review, with strict scrutiny as the controlling

Court may seek an opportunity to revisit affirmative action in higher education. In fact, the Court at the end of its most recent term decided a pair of cases invalidating public school district plans that used student race as a primary factor in school assignments in order to maintain racial balance in the classroom.[15]

The Court's initial decision to hear these cases provoked some surprise among commentators who observed that, in December of 2005, with Justice O'Connor still on the Court, the justices declined to hear a challenge to an almost identical school integration plan.[16] In addition, the three federal circuits to hear such challenges since the *Gratz* and *Grutter* decisions all upheld the school district plans in question, leaving no circuit split for the Court to resolve.[17] In deciding the public school cases, the Court avoided direct reconsideration of the higher education decisions from 2003, and in fact explicitly distinguished *Grutter*,[18] but the Court's decision to invalidate these school district desegregation plans certainly opens the door to further discussion and undoubtedly will impact the debate about appropriate means to achieve racial diversity in the classroom and the intrinsic value of diversity as an educational goal.[19] Even if the

---

standard," which, in Kennedy's opinion, the majority did not apply in *Grutter*. *See* 539 U.S. 306, 387–88 (Kennedy, J., dissenting) (describing the majority's review of the Michigan Law School's race conscious admissions program as "nothing short of perfunctory").

[15] *See* Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1, No. 05-908, *together with* Meredith v. Jefferson County Bd. of Educ., 127 S. Ct. 2738, 2768 (2007) (holding that the school districts did not meet the burden of showing a compelling justification for discriminating on the basis of race); *see also* Robert Barnes, *Court Hears Cases on Schools and Race; Diversity Plans Challenged In Name of Equal Protection*, WASH. POST, Dec. 5, 2006, at A03, *available at* LEXIS, News Library, WPOST File (noting that the Bush administration had filed a brief on behalf of white parents challenging the school districts' school assignment policies and suggesting that the oral argument seemed to reflect "a court majority highly skeptical of the proposition that the benefits of racially diverse public schools can justify any restriction on an individual's constitutional right to equal protection"). The pair of cases has generated a "blizzard" of briefs on both sides of the issue. Robert Barnes, *Supreme Court to Review Two School-Integration Plans; Justices to Consider Whether Race Can Still Be a Factor in Public School Placement*, WASH. POST, Dec. 3, 2006, at A03, *available at* LEXIS, News Library, WPOST File.

[16] *See* Linda Greenhouse, *Court to Weigh Race as a Factor in School Rolls*, N.Y. TIMES, June 6, 2006, at A1, *available at* LEXIS, News Library, NYT File (explaining that "[w]hat has changed is the Supreme Court itself, with the retirement in January of Justice O'Connor and her replacement by Justice Samuel A. Alito Jr."). The decision to grant certiorari on these cases also was controversial within the Court, with the justices considering the Seattle case six times and the Louisville case seven times before finally accepting the cases for review. *Id.*

[17] *See* Charles Lane, *Justices to Hear Cases of Race-Conscious School Placements*, WASH. POST, June 6, 2006, at A03, *available at* LEXIS, News Library, WPOST File (noting that this will be "the first race-related constitutional case for President Bush's two appointees, Chief Justice John G. Roberts and Justice Samuel A. Alito Jr." and quoting a former Clinton administration official who suggested that "the more conservative justices see that they have a fifth vote to reverse these [school desegregation] cases").

[18] *See Parents*, 127 S. Ct. at 2757 (noting that in *Grutter* the law school did not count backward to find a meaningful number of minority students, while in the present case the schools worked backward to achieve a particular type of racial balance).

[19] In fact, "several conservative legal organizations [were] urging the court in friend-of-the-court briefs to use the Seattle and Louisville cases to overrule the [*Grutter*] decision." Charles Lane, *Justices*

Court declines in the future to revisit the constitutionality of higher education affirmative action programs such as the one in *Grutter*, increasing litigation and legislative activity as well as growing public debate concerning the appropriateness of affirmative action will continue to have an adverse impact on the representation of certain minority groups in medical schools and ultimately in the medical profession. State initiatives prohibiting race-conscious university admissions policies already have chipped away at the practice in a number of states.[20] Organizations such as the United States Commission on Civil Rights have criticized race-blind alternatives to affirmative action for failing to assist students of color who are not at the top of their high school classes and for significantly decreasing diversity in graduate level education.[21] Pro-affirmative action organizations have expressed the well-justified concern that the Michigan decisions will galvanize opponents of the process into action at the state level.[22] Even after the *Grutter* decision in 2004, eight

---

to Hear Abortion, Integration Cases; *'Partial-Birth' Procedure and Schools' Race Policies to Dominate Court's Agenda*, WASH. POST, Oct. 1, 2006, at A06 *available at* LEXIS, News Library, WPOST File.

[20] *See, e.g.*, CAL. CONST., art. I, § 31(a); WASH. REV. CODE ANN. § 49.60.400(1) (West 2007) ("The state shall not discriminate against, or grant preferential treatment to, any individual or group on the basis of race, sex, color, ethnicity, or national origin in the operation of public employment, public education, or public contracting."); *see also* Alyson Klein, *Affirmative-Action Opponents Suffer Setbacks in Colorado and Michigan*, CHRON. HIGHER EDUC. Apr. 9, 2004, at 23 *available at* LEXIS, News Library, CHEDUC File (describing the course of litigation in several states).

[21] One race-neutral alternative to affirmative action, percentage plans that admit a specified class rank percentage of students from each high school to a state university, has created mixed results—although minority enrollment overall remained fairly steady, students of color whose class rank did not meet the state requirement were far less likely to be admitted to state colleges and many students admitted under the plan were unable to attend the college of their choice. *See* U.S. COMM'N ON CIVIL RIGHTS, TOWARD AN UNDERSTANDING OF PERCENTAGE PLANS IN HIGHER EDUCATION: ARE THEY EFFECTIVE SUBSTITUTES FOR AFFIRMATIVE ACTION? (2000), *available at* http://www.usccr.gov/pubs/percent/stmnt.htm (explaining with respect to the Texas plan that "a color-blind law in a racially segregated primary and secondary public school environment can promote some diversity in undergraduate admissions. However, the adverse impact on the admission of black and Hispanic high school students not in the top 10 percent shows that UT-Austin's failure to increase the yield while implementing the Texas Plan creates an ineffective replacement program when compared with the university's previous affirmative action policy. Severe decreases in the number of minority students enrolled in UT-Austin's graduate and professional schools enforce the need for race-conscious affirmative action"). Florida's version of the percentage plan fared even worse in the Commission's evaluation. *See id.* ("[Jeb] Bush's program, unlike that in Texas, does not require the state's most prestigious flagship institutions to admit students in the top [twenty] percent, if they choose to attend. The Plan also makes no provisions for students who are qualified for admission but who are not in the top [twenty] percent of their class. The Plan is an unprovoked stealth acknowledgment—and acceptance—that the existing school and housing segregation will never change and that longstanding efforts to remedy the race discrimination that was legal in Florida have been abandoned. The Plan also voluntarily abolishes affirmative action with nothing to replace it that will ensure inclusion for people of color in graduate and professional education.") (footnotes omitted); *see also* Jennifer L. Shea, Note, *Percentage Plans: An Inadequate Substitute for Affirmative Action in Higher Education Admissions*, 78 IND. L.J. 587, 616–17 (2003) (criticizing the effectiveness of percentage plans for fostering integration in higher education and noting that such plans generally do not apply to graduate and professional schools and do nothing to encourage diversity of classes in these settings).

[22] *See, e.g.*, AMERICANS FOR A FAIR CHANCE, ANTI-AFFIRMATIVE ACTION THREATS IN THE

anti-affirmative action legislative initiatives were introduced in three states and such efforts continue to this day.[23] In fact, in November of 2006, fifty-eight percent of voters in Michigan approved a ballot initiative to amend the state's constitution to prohibit affirmative action in higher education admissions, public employment, and public contracting.[24] Opponents of the measure immediately filed a legal challenge to the amendment in the U.S. District Court.[25] The battle over affirmative action will continue.

Part II of this Article lays out the evidence documenting racial disparities in the provision of health care that contribute to poorer health outcomes for African Americans and several other minority groups. Part III provides an overview of some of the key constitutional decisions that have recognized and developed the position that racial and ethnic diversity represents a compelling governmental interest justifying the appropriate use of such classifications in higher education admissions. Part IV explores in depth the function of diversity in medical education and its connection with improved quality of care and provides some suggested approaches for tackling these challenges. Finally, Part V acknowledges the unanswered questions that remain in the conversation about race and health care quality.

II. THE RACE GAP IN HEALTH CARE DELIVERY

An enormous body of well-designed scientific research demonstrates that minorities, particularly African Americans, experience a statistically higher likelihood of poorer health, earlier disability, and earlier death, compared to white Americans.[26] Significant health disparities between

---

STATES: 1997–2004 (2005), *available at* http://fairchance.civilrights.org/the_facts/reports/aa_state_2005.pdf (providing a summary of state legislation in twenty-eight states, ballot initiative efforts in three states, and state executive orders in one state attempting to limit or end affirmative action).

[23] *See id.* at 3–4 (describing efforts in Colorado, Massachusetts, and New Jersey in 2004).

[24] The Michigan Civil Rights Initiative, Vote Yes! on 2, http://www.michigancivilrights.org/ballotlanguage.html (last visited Nov. 12, 2007); The Michigan Civil Rights Initiative, Official Ballot Language, http://www.michigancivilrights.org/ballotlanguage.html (last visited Nov. 12, 2007).

[25] *See* Complaint at 2, 6–7, Coalition to Defend Affirmative Action, Integration and Immigrant Rights and Fight for Equality By Any Means Necessary (BAMN) v. Granholm, 240 F.R.D. 368, (E.D. Mich., Dec. 27, 2006), *available at* http://www.bamn.com/doc/2006/061108-complaint-prop2.pdf (claiming that the measure is invalid because it violates the Equal Protection Clause of the Fourteenth Amendment and it violates the First Amendment as interpreted by *Grutter v. Bollinger*).

[26] *See* Murray et al., *supra* note 2, at 1514, 1524 (finding that "health inequalities in the U.S. are large and are showing no sign of reducing"). Much of this research was summarized in MOREHOUSE MED. TREATMENT & EFFECTIVENESS CENTER, MOREHOUSE SCHOOL OF MEDICINE, A SYNTHESIS OF THE LITERATURE: RACIAL AND ETHNIC DIFFERENCES IN ACCESS TO MEDICAL CARE (1999), *available at* http://kff.org/minorityhealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13293 (summarizing health literature from 1985 to 1999, including 180 studies—some controlling for explanatory variables and some not—that provide evidence of racial disparities in health services). Much of the following discussion focuses on health disparities between African American and white patients, and on the relationship between white physicians and African American patients, in part because most of the studies evaluating patterns of care focus on the contrasts between these two racial

minorities and whites persist despite identification of this pattern and repeated calls for responses from the medical community.[27] Certainly cost-driven treatment decisions are an unavoidable reality for most patients,[28] but other longstanding inequities in the delivery of health care services pose formidable problems for patients of color and the health care community continues to struggle to understand the underlying causes of health disparities.[29] The correlation between health disparities and disparities in the quality of health care delivery received by whites versus racial and ethnic minorities is well-documented. As the Institute of Medicine explained in a recent analysis of the issue, "[r]acial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable."[30]

Patients of color have expressed a continuing distrust in the health care

---

groups. *See, e.g.*, Council on Ethical & Judicial Affairs, *Black-White Disparities in Health Care*, 263 J. AM. MED. ASS'N 2344, 2344 (1990) (focusing on health care disparities between black and white Americans). Some scholars have, appropriately, criticized the application of conclusions about relations between whites and African Americans to white relations with other minority groups. *See generally* Juan F. Perea, *The Black/White Binary Paradigm of Race: The "Normal Science" of American Racial Thought*, 85 CAL. L. REV. 1213 (1997) (noting the limitations of black-white paradigms). Because the discussion that follows emphasizes the importance of physicians' getting to know their patients as individuals and the importance of individualized medical decision-making, however, many of the suggestions apply equally well to relations between physicians and patients of any race or ethnicity.

[27] *See generally* INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 6 (Brian D. Smedley et al. eds., 2003) [hereinafter UNEQUAL TREATMENT] (recommending an increased "awareness of racial and ethnic disparities in healthcare among the general public and key stakeholders"); AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVICES, NATIONAL HEALTHCARE DISPARITIES REPORT 117–130 (2005), *available at* http://www.ahrq.gov/qual/Nhdr05/nhdr05.pdf [hereinafter NATIONAL HEALTHCARE DISPARITIES REPORT] (providing statistics about race based disparities in both access to and quality of care).

[28] *See* David Orentlicher, *Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick*, 31 HARV. C.R.-C.L. L. REV. 49, 49 (1996) (concluding that "rationing of health care is inevitable").

[29] *See* Christopher Lee, *Studies Look for Reasons Behind Racial Disparities in Health Care*, WASH. POST, Oct. 25, 2006, at A10, *available at* LEXIS, News Library, WPOST File (explaining that race disparities in health delivery are well documented but that researchers cannot easily pinpoint their causes and suggesting that poverty, lack of education, cultural differences, and subtle racism may all contribute to the problem).

[30] UNEQUAL TREATMENT, *supra* note 27, at 6. The influence of race on health care is less visible today than it was in the past, but, until very recently, patient race influenced health care delivery in significant ways beginning with the manner in which academic medical centers operated. In the mid-20th century, teaching hospitals, particularly in the South, had segregated wards for African American patients and some of these hospitals used only African American patients for student teaching. KENNETH M. LUDMERER, TIME TO HEAL: AMERICAN MEDICAL EDUCATION FROM THE TURN OF THE CENTURY TO THE ERA OF MANAGED CARE 120 (1999). In the 1960s academic medical centers in the inner cities still tended to mirror the racial hierarchy of society. *Id.* at 262. The professional staffs at these hospitals were predominately white, while the laundry, food service, and janitorial staffs were mainly African American or Hispanic. *Id.* Although teaching hospitals no longer segregate patients by race or use minority patients exclusively for teaching, to the extent that the color divide between professional staff and service providers lingers, it probably impacts the experience of minority patients, particularly at inner-city teaching hospitals.

system and in individual medical providers, and with good reason.[31] An astonishing number of studies document health disparities between the races and conclude that factors such as genetic differences, lifestyle choices, and variations in access to medical care fail to account fully for these health disparities.[32] Numerous studies concerning virtually every type of medical care strongly suggest that African American patients do not receive the same care as white patients when they seek medical treatment.[33] For example, the utilization rates of coronary drugs and complex coronary procedures,[34] racial disparities in access to organ transplantation,[35] frequency of knee arthroplasty,[36] and disparities in the

---

[31] *See* Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 VILLANOVA L. REV. 195, 196 (2003) (describing the connection between physician bias and patient trust and noting that "[a] patient's trust in his physician to act in the patient's best interest . . . allows him to share private information . . . and to rely on the physician's expert advice regarding diagnosis and treatment"); Barbara A. Noah, *The Participation of Underrepresented Minorities in Clinical Research*, 29 AM. J. L. & MED. 221, 229–31 (2003) (describing research abuses perpetrated against minority populations and discussing strategies to generate trust in these communities in order to improve participation in clinical trials); Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191, 191–92 (1996).

[32] *See, e.g.* Barbara A. Noah, *The Invisible Patient*, 2002 U. ILL. L. REV. 121, 121–22, 130–31 (2002) [hereinafter Noah, *Invisible Patient*]; Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135, 138–55 (1998) [hereinafter Noah, *Racial Disparities*] (providing detailed descriptions of disparate provision of care in a variety of settings).

[33] *See e.g.* MARSHA LILLIE-BLANTON & CAYA B. LEWIS, POLICY CHALLENGES AND OPPORTUNITIES IN CLOSING THE RACIAL/ETHNIC DIVIDE IN HEALTH CARE 1 (2005), *available at* http://www.kff.org/minorityhealth/upload/Policy-Challenges-and-Opportunities-In-Closing-the-Racial-Ethnic-Divide-in-Health-Care-Issue-Brief.pdf (concluding that "[r]acial and ethnic disparities in health care—whether in insurance coverage, access, or quality of care—are one of many factors producing inequalities in health status in the United States").

[34] *See, e.g.*, Jeroan J. Allison et al., *Racial Differences in the Medical Treatment of Elderly Medicare Patients with Acute Myocardial Infarction*, 11 J. GEN. INTERNAL MED. 736, 736 (1996); John G. Canto et al., *Relation of Race and Sex to the Use of Reperfusion Therapy in Medicare Beneficiaries with Acute Myocardial Infarction*, 342 NEW ENG. J. MED. 1094, 1096–97 (2000) (concluding that African Americans were less likely than whites to receive "potentially lifesaving" reperfusion therapy); Herman A. Taylor, Jr. et al., *Management and Outcomes for Black Patients with Acute Myocardial Infarction in the Reperfusion Era*, 82 AM. J. CARDIOLOGY 1019, 1020–21 (1998) (concluding that African Americans are less likely than whites to receive intravenous thrombolytic therapy, coronary arteriography, and other elective catheter-based procedures).

[35] *E.g.*, John Z. Ayanian et al., *The Effect of Patients' Preferences on Racial Differences in Access to Renal Transplantation*, 341 NEW ENG. J. MED. 1661, 1661 (1999) (finding that "preferences and expectations with respect to renal transplantation among patients with end-stage renal disease differ according to race"); Arnold M. Epstein et al., *Racial Disparities in Access to Renal Transplantation: Clinically Appropriate or Due to Underuse or Overuse?*, 343 NEW ENG. J. MED. 1537, 1542 (2000) (finding that "blacks also appear to receive fewer transplants, regardless of the clinical indications"); *see also* Laura Johannes, *Delicate Surgery: In Kidney Quest, New Rules Boost Chances for Blacks—Reform Seeks to Close Gap in Transplant Wait Times*, WALL ST. J. June 18, 2004, at A1, *available at* LEXIS, News Library, WSJNL File (describing reforms in rules governing allocation of kidneys for transplant that attempt to reduce racial disparities in waiting times).

[36] *See* Jonathan Skinner et al., *Racial, Ethnic, and Geographic Disparities in Rates of Knee Arthroplasty Among Medicare Patients*, 349 NEW ENG. J. MED. 1350, 1350–51, 1356 (2003) (finding that the rate of surgical treatment for arthritis of the knee "varies dramatically" according to sex, race and ethnicity, and region of the country, and concluding that geography contributed to a portion of the racial variations); *see also* Mary E. Charlson & John P. Allegrante, *Disparities in the Use of Total Joint*

provision and availability of pain medications[37] suggest that African Americans and other minorities receive different care than white patients.[38] Another study documented substantial delays in breast cancer diagnosis and treatment for African American women compared with white women,[39] and yet another found that African American women were significantly less likely than white women to undergo genetic testing for increase risk of breast and ovarian cancer.[40]

Although patient preferences may play a role in certain disparities in the utilization of medical procedures, there is real racial and cultural bias at work as well, at least some of the time.[41] A couple of recent examples starkly illustrate the problem. In one highly publicized study, researchers

---

Arthroplasty, 342 NEW ENG. J. MED. 1044, 1044–45 (2000) (summarizing findings of similar disparities by race and arguing for educational interventions to reduce disparities).

[37] *See, e.g.*, Vence L. Bonham, *Race, Ethnicity, and Pain Treatment: Striving to Understand the Causes and Solutions to the Disparities in Pain Treatment*, 29 J.L. MED. & ETHICS 52, 52 (2001) (finding "[r]acial and ethnic minority populations are at higher risk for . . . ineffective treatment of pain"); R. Sean Morrison et al., *"We Don't Carry That"—Failure of Pharmacies in Predominantly Nonwhite Neighborhoods to Stock Opioid Analgesics*, 342 NEW ENG. J. MED. 1023, 1023 (2000) (concluding that "[p]harmacies in predominantly non-white neighborhoods of New York City do not stock sufficient medications to treat patients with severe pain adequately"); Knox H. Todd et al., *Ethnicity and Analgesic Practice*, 35 ANNALS EMERGENCY MED. 11, 13 (2000) (finding that, in the studied group of patients presenting in an emergency department with long-bone fractures, only fifty-seven percent of African Americans received analgesics compared with seventy-four percent of white patients); Knox H. Todd et al., *Ethnicity as a Risk Factor for Inadequate Emergency Department Analgesia*, 269 J. AM. MED. ASS'N 1537, 1537 (1993) (finding that "Hispanics with isolated long-bone fractures [were] twice as likely as non-Hispanic whites to receive no pain medication").

[38] Examples of disparate treatment by race continue to mount. *See, e.g.*, Ashish K. Jha et al., *Racial Trends in the Use of Major Procedures Among the Elderly*, 353 NEW ENG. J. MED. 683, 683 (2005) (finding accelerating differences in rates of utilization in five of nine surgical procedures among elderly patients enrolled in Medicare, and concluding that efforts to eliminate disparities in the use of high-cost surgical procedures were ineffective); Amal N. Trivedi et al., *Trends in the Quality of Care and Racial Disparities in Medicare Managed Care*, 353 NEW ENG. J. MED. 692, 692 (2005) (finding that racial disparities continued but appeared to be declining among the populations studied); Viola Vaccarino et al., *Sex and Racial Differences in the Management of Acute Myocardial Infarction, 1994 Through 2002*, 353 NEW ENG. J. MED. 671, 671 (2005) (concluding that rates of several treatments for heart attack varied significantly by race and that the differences in rates of utilization have not improved in the later years).

[39] *See* Sherri Sheinfeld Gorin et al., *Delays in Breast Cancer Diagnosis and Treatment By Racial/Ethnic Group*, 166 ARCHIVES INTERNAL MED. 2244, 2244 (2006) (finding that, after controlling for other predictors, African American women had a 1.39 fold odds of diagnostic delay beyond two months, a 1.64 fold odds of treatment delay beyond one month, and a 2.24 fold odds of having a combined diagnosis and treatment delay and concluding that neutral confounding variables alone fail to explain these disparities in timeliness of diagnosis).

[40] *See* Katrina Armstrong et al., *Racial Differences in the Use of BRCA 1/2 Testing Among Women With Family History of Breast or Ovarian Cancer*, 293 J. AM. MED. ASS'N 1729, 1734 (2005) (finding that the disparities in genetic counseling and testing were not explained by variables such as socioeconomic status, cancer risk perception and worry, attitudes about genetic testing, or primary care physician discussions of testing and speculating that newer technologies such as genetic testing "may be particularly sensitive to the effects of distrust" in the health care system among African Americans).

[41] *See* Risa Lavizzo-Mourey & James R. Knickman, *Racial Disparities—The Need for Research and Action*, 349 NEW ENG. J. MED. 1379, 1380 (2003) (explaining that "[a] critical next step will be careful research designed to clarify how much of the difference is due to beliefs and preferences . . . and how much is due to bias or stereotyping on the part of health care providers" and calling on health care providers and insurers to measure racial disparities within their patient populations).

found that physicians referred lower percentages of African American patients than white patients for cardiac catheterization, even when all other factors, i.e., age, sex, and severity of disease, were equal.[42] Some studies clearly suggest that even when experts agree on an optimal intervention for a particular medical condition, African American patients may receive that treatment less frequently when they seek care. To take one striking example, several studies have demonstrated that African Americans are less likely to receive surgical treatment of early-stage lung cancer than whites, and, consequently, have a lower overall survival rate for the disease.[43] These differential utilization patterns persist even when investigators control for confounding variables such as income, level of education, insurance coverage, co-morbid conditions, and stage of

---

[42] *See* Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618, 621–23 (1999) (finding that "the race and sex of the patient affected the physicians' decisions about whether to refer patients with chest pain for cardiac catheterization" even though there were no differences as to chest pain). The New England Journal later published corrections and a partial retraction of the research because the study received an enormous amount of public attention, including criticism about its design and methodology, some of which was valid. *See* Lisa M. Schwartz et al., *Misunderstandings About the Effects of Race and Sex on Physicians' Referrals for Cardiac Catheterization*, 341 NEW ENG. J. MED. 279, 279–82 (1999) (responding to media attention and clarifying the findings).

[43] *See* Howard P. Greenwald et al., *Social Factors, Treatment, and Survival in Early-Stage Non-Small Cell Lung Cancer*, 88 AM. J. PUB. HEALTH 1681, 1682–83 (1998) (finding that white patients were twenty percent more likely to undergo surgery than African American patients, and were thirty-one percent more likely to survive five years, and commenting that "[p]oor general health and adverse health behavior (such as smoking), which often coincide with low income and membership in minority groups, may lead to lower rates of surgery as providers judge disadvantaged patients to be relatively poor surgical risks") (footnote omitted); Peter B. Bach et al., *Racial Differences in the Treatment of Early-Stage Lung Cancer*, 341 NEW ENG. J. MED. 1198, 1198 (1999) (concluding that the lower survival rate among black for early-stage lung cancer is largely explained by the lower rate of surgical treatment). As I explained in an earlier article on racial disparities in health care delivery,

> [This] recent study followed nearly 11,000 lung cancer patients over the course of eight years and controlled for variables including disease stage, insurance coverage, socioeconomic status, access to care, and coexisting illness. The investigators found that African Americans underwent surgical resection of the cancer only sixty-four percent of the time, compared with a rate of nearly seventy-seven percent for white patients in the studied group. The five-year survival rate for the African American group was correspondingly lower—approximately twenty-six percent versus thirty-four percent of white patients—whereas the five-year survival rate among patients who *had* undergone surgery was the same in both racial groups. Most strikingly, however, surgical resection incontrovertibly represents the optimal treatment for early-stage lung cancer, leaving little room for the argument that some other, less common, but equally effective, treatment was indicated for any particular patient. Two physicians, commenting on this study, lament that the results "suggest that there is a difference in how physicians manage cancer that is based on the patient's race, regardless of other attributes, and that the consequence of these lapses in care is reduced survival among blacks. Evidence that bias on the part of physicians (either overt prejudice or subconscious perceptions) influences access to optimal cancer care is disheartening."

Noah, *Invisible Patient*, *supra* note 32, at 129 (citing Bach et al., *supra*, at 1201–02 and Talmadge E. King, Jr. & Paul Brunetta, *Racial Disparity in Rates of Surgery for Lung Cancer*, 341 NEW ENG. J. MED. 1231, 1231–32 (1999)).

disease.[44]

At least some of these variations in quality of care appear to spring from unconscious bias in individual health care providers.[45] Measuring this sort of racial bias and its impact on clinical decision-making presents very real challenges, and designing well-controlled, targeted studies remains difficult.[46] In the most recent study attempting to document the effect of unconscious racial bias on clinical decision-making, researchers found a striking correlation between the presence of implicit negative stereotypes of African Americans and a decreased likelihood to provide appropriate medical treatment.[47] In commenting on the research, one co-author suggested that the physicians studied appeared to have unknowingly internalized racial stereotypes that had a subtle influence on their clinical judgment.[48] As the authors conclude,

> [i]mplicit racial biases are prevalent in the United States in general, and as such it should not be surprising that they are prevalent among physicians as well . . . . [Such biases] may affect the behavior even of those individuals who have nothing but the best intentions, including those in the medical professions.[49]

Of course, not all health disparities between the races result from bias in health care delivery or disparities in access to care. As one commentator has observed, "two truths . . . may seem contradictory but aren't: 1) There is epidemic racism in this country. 2) You can find racism where it does

---

[44] *See* Noah, *Invisible Patient*, *supra* note 32, at 130–31.

[45] *See* Arnold M. Epstein & John Z. Ayanian, *Racial Disparities in Medical Care*, 344 NEW ENG. J. MED. 1471, 1472 (2001) (discussing the results of a study identifying disparities in rates of cardiac catheterization and suggesting that "both white and black physicians may have subtle biases . . . that influence their judgments about patients' suitability for procedures").

[46] *See generally* Crossley, *supra* note 31, at 205–11 (providing an insightful description of research design and implementation problems and explaining that, when medical treatment is discretionary, it is particularly difficult to isolate the role of bias in the decision to provide or refrain from providing a particular treatment option); *see also infra* notes 163–67 and accompanying text (discussing physician discretion in clinical decision-making and its connection to cultural competence in medicine).

[47] *See* Alexander R. Green et al., *Implicit Bias Among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 J. GEN. INTERNAL MED. 1231 (2007). In the study, researchers tested physicians for unconscious racial bias using a well-regarded series of psychological tests called Implicit Association Tests (IATs). After measuring the degree of bias in participating physicians, researchers presented each participant with a medical vignette of a patient presenting with symptoms of heart attack and asked whether they would recommend treatment with thrombolytic therapy. Participants with higher levels of unconscious bias as measured by the IATs were substantially less likely to recommend thrombolytic therapy for African American patients than for white patients with otherwise identical medical conditions. *Id.* at 1235.

[48] Shankar Vedantam, *The Color of Health Care: Diagnosing Bias in Doctors*, WASH. POST, Aug. 13, 2007, at A03, *available at* LEXIS, News Library, WPOST file (describing and discussing the study in the context of racial bias in other settings and suggesting that this sort of unconscious racial bias "is at odds with conventional views of bigotry—and perhaps more insidious").

[49] *See* Green et al., *supra* note 47, at 1236.

not exist."[50] A complex interplay between socioeconomic status, education, lifestyle decisions and other behaviors, patterns of utilization of health services, and genetics influences the prevalence of disease in different racial and ethnic groups.[51] Even more broadly, larger inequalities in society, such as discrimination in housing, employment, income distribution, education, and exposure to violence contribute to an increased risk of disease among minority populations.[52] Nevertheless, evidence demonstrates the persistent effects of racial bias on the quality of medical care received by minority patients and the impact of this phenomenon in perpetuating health disparities. As a result, commentators have called for action to prevent bias and its effects on health.[53]

III. THE DIVERSITY RATIONALE IN AFFIRMATIVE ACTION CASE LAW

The continued viability or ultimate demise of the diversity rationale in higher education admissions obviously has the potential to exert a significant effect on the representation of different races, cultures, and religions in the student populations of medical schools. The Supreme Court has interpreted the Equal Protection Clause to forbid state-funded

---

[50] Leonard Pitts, Jr., *Sometimes, Our Suspicions Are Unfounded*, MIAMIHERALD.COM, July 8, 2007, http://origin.miami.com/mld/miamiherald/living/columnists/leonard_pitts/17464350.htm.

[51] *See generally* Mike Bamshad, *Genetic Influences on Health: Does Race Matter?*, 294 J. AM. MED. ASS'N 937 (2005) (explaining that genetic information and accurate information about geographic ancestry serve as more accurate predictors of genetic disease than self-described membership in a particular racial group); Lisa A. Carey et al., *Race, Breast Cancer Subtypes, and Survival in the Carolina Breast Cancer Study*, 295 J. AM. MED. ASS'N 2492 (2006) (concluding that the higher prevalence of a more difficult to treat subtype of breast cancer among young African American women contributed to the poorer prognosis in this group and recommending further study to evaluate race in relation to other variables such as stage of cancer at diagnosis and presence of genetic mutations that contribute to cancer risk); Ronnie D. Horner et al., *Theories Explaining Racial Differences in the Utilization of Diagnostic and Therapeutic Procedures for Cerebrovascular Disease*, 73 MILBANK Q. 443 (1995) (exploring in depth alternative explanations to racism in the context of disparities in treatment of stroke). On the complex interaction of genetics and lifestyle choices with respect to risk of lung cancer, see generally Christopher A. Haiman et al., *Ethnic and Racial Differences in the Smoking-Related Risk of Lung Cancer*, 354 NEW ENG. J. MED. 333, 335–39 (2006) (concluding that African Americans and Native Hawaiians who smoke are more likely to develop lung cancer than Caucasians, Latinos, or Japanese Americans and suggesting that diet, smoking behavior and other factors contribute to the differences in cancer susceptibility); Neil Risch, *Dissecting Racial and Ethnic Differences*, 354 NEW ENG. J. MED. 408 (2006) (explaining that "it is . . . difficult to discuss the role of genetics in differences among groups, because of the fear that such discourse may reinforce notions of biologic determinism" and observing that "a more balanced perspective allows for interactions between genetic and environmental factors in disease causation; both can vary between populations and jointly underlie differences among groups") (footnote omitted).

[52] *See* JAMES L. CURTIS, AFFIRMATIVE ACTION IN MEDICINE: IMPROVING HEALTH CARE FOR EVERYONE 202 (2003) (quoting David R. Williams & Toni D. Rucker, *Understanding and Addressing Racial Disparities in Health Care*, MINORITY HEALTH TODAY, Summer 2000, at 75, 79–80).

[53] *See, e.g.*, Crossley, *supra* note 31, at 244–77 (exploring a variety of legal avenues to challenge biased health care delivery); Kevin Outterson, *Tragedy and Remedy: Reparations for Disparities in Black Health*, 9 DEPAUL J. HEALTH CARE L. 735, 778–91 (2005) (making a strong case for reparations and arguing specifically that addressing black health disparities as a reparations matter "may challenge American society to move beyond token responses").

colleges and universities from considering race in admissions unless the admissions policy is narrowly tailored and promotes a compelling governmental interest.[54] In the late 1970s, the Supreme Court began to entertain the idea that racial and ethnic diversity in higher education serves important educational goals and can sometimes justify race-conscious admissions policies.

In its famous 1978 decision in *Bakke*, the Court considered whether the University of California at Davis's medical school admissions process violated the equal protection clause of the United States Constitution and Title VI of the Federal Civil Rights Act of 1964.[55] Three of the Justices believed that the Davis program ran afoul of Title VI.[56] Four different Justices concluded that the Davis program was permissible under both the equal protection clause and Title VI.[57] Justice Powell, who cast the deciding vote, believed that the program was invalid under the Equal Protection clause and therefore rejected admissions quotas and set-asides used by the University of California.[58] Nevertheless, he concluded that some affirmative action admissions programs could survive constitutional scrutiny by considering race as one of several factors in making

---

[54] The Fourteenth Amendment states, in relevant part, "nor shall any State . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1. For an overview of key Supreme Court decisions dealing with affirmative action in higher education and the narrow tailoring question, see BOWEN & BOK, *supra* note 6, at 13–14.

[55] 42 U.S.C. § 2000d (2000); Regents of the Univ. of Cal. v. Bakke, 438 U.S. 265, 270–71 (1978). Title VI of the Civil Rights Act of 1964 prohibits racial discrimination by any public or private college or university that receives federal funding, providing that "[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 42 U.S.C. § 2000d. Alan Bakke, a white male applicant who was rejected from the medical school, challenged the university's admissions practices, claiming that certain of these practices interfered with his opportunity to be admitted. *Bakke*, 438 U.S. at 277–78. The school had set aside sixteen out of one hundred places in its entering class for racial minorities and used a "special admissions program" with a separate committee to consider "economically and/or educationally disadvantaged" applicants and members of a "minority group." The preferred racial minorities under the program were African Americans, Native Americans, Asians, and Hispanics. *Bakke*, 438 U.S. at 274. Under the special admissions process, applicants were not required to meet the 2.5 grade point average threshold required in the general admissions process and special process admittees had significantly lower scores on the Medical College Admissions Test (MCAT). The average GPA of special admittees in the entering class in 1973 was 2.62; the average of regular admittees was 3.51, and Bakke's GPA was 3.44. In 1974, when Bakke applied a second time, the average GPA of special admittees was 2.42, that of regular admittees was 3.36, and Bakke re-submitted his 3.44. Bakke's MCAT scores were significantly higher than the average of regular admittees and dramatically higher than the average scores of candidates admitted through the special program. *Bakke*, 438 U.S. at 277–78 n.7.

[56] *Bakke*, 438 U.S. at 408–21 (Stevens, Stewart, and Rehnquist, J.J., and Burger, C.J., concurring in part).

[57] *Id.* at 324–55 (Blackman, Brennan, Marshall, and White, J.J., dissenting in part).

[58] *Id.* at 320. Note that the Supreme Court in *Bakke* only held that the Davis program violated Title VI; no group of five justices actually voted that the program violated the equal protection clause. JOHN E. NOWAK & RONALD D. ROTUNDA, CONSTITUTIONAL LAW 810 (7th ed. 2004). Title VI also prohibits private colleges and universities that receive federal funding from implementing admissions programs that use strict racial quotas. *Id.* at 809.

individualized admissions decisions.[59]

Justice Powell's separate opinion offered a different rationale in support of certain affirmative action admissions policies, discussing with approval the university's goal of attaining a diverse student body.[60] The opinion concluded that diversity in the classroom could enhance education by introducing students to the novel opinions and experiences of their classmates.[61] In favorably describing the admissions program at Harvard College, Justice Powell explained that *all* students benefit from learning in a diverse class setting:

> Contemporary conditions in the United States mean that if Harvard College is to continue to offer a first-rate education to its students, minority representation in the undergraduate body cannot be ignored by the Committee on Admissions. . . . [T]he race of an applicant may tip the balance in his favor just as geographic origin or a life spent on a farm may tip the balance in other candidates' cases. A farm boy from Idaho can bring something to Harvard College that a Bostonian cannot offer. Similarly, a black student can usually bring something that a white person cannot offer. The quality of the educational experience of all the students . . . depends in part on these differences in the background and outlook that students bring with them.[62]

Nevertheless, the opinion provided only limited endorsement for the use of racial preferences in higher education admissions, rejecting Davis's procedure of setting aside a specific number of places for racial minorities and preferring Harvard's holistic approach to evaluating candidates, in

---

[59] *See Bakke*, 438 U.S. at 320 ("In enjoining [the University of California at Davis] from ever considering the race of any applicant, however, the courts below failed to recognize that the State has a substantial interest that legitimately may be served by a properly devised admissions program involving the competitive consideration of race and ethnic origin."). Although the Powell opinion was controlling as to the outcome, the other justices disagreed with his analysis of the Equal Protection and Title VI questions. For this reason, only Powell's statement of the facts and his conclusion that some racial classifications in this context could be constitutionally valid were joined by four other justices. *Id.* at 271–84, 320.

[60] *Id.* at 311–15. Justice Powell noted that the university invoked a countervailing constitutional interest in the First Amendment explaining that the:

> [A]ttainment of a diverse student body . . . clearly is a constitutionally permissible goal for an institution of higher education. Academic freedom, though not a specifically enumerated constitutional right, long has been viewed as a special concern of the First Amendment. The freedom of a university to make its own judgments as to education includes the selection of its student body.

Id. at 311–12.

[61] *See id.* at 312 ("The atmosphere of 'speculation, experiment and creation'—so essential to the quality of higher education—is widely believed to be promoted by a diverse student body.") (footnote omitted).

[62] *Id.* at 322–23 (appendix to opinion of Powell, J.).

which race may serve as a "plus" for an otherwise qualified candidate.[63] In response to Powell's opinion, many institutions of higher education attempted to implement a holistic approach to admissions, including consideration of race.

Interestingly, the Powell opinion briefly explored the operation of diversity specifically in the medical school context, although it also suggested that there may be "greater force to these views at the undergraduate level than in a medical school where the training is centered primarily on professional competency."[64] Justice Powell explained that, because physicians treat a heterogeneous population of patients, otherwise qualified medical students with diverse racial, ethnic, geographic, or other backgrounds may contribute to medical school ideas and viewpoints that enrich the educational experience for all students, making them better able to "render with understanding their vital service to humanity."[65] Most of the Powell opinion, however, considered the constitutionality of affirmative action in higher education as a general matter, suggesting that classroom diversity as a compelling governmental interest carries the same force in all higher education contexts.

Finally, Justice Powell also evaluated the university's argument that its special admissions program would improve the delivery of health services to underserved communities.[66] Although he acknowledged that a State's interest in facilitating health care to its citizens may sometimes be sufficiently compelling to justify the use of racial classifications, he noted that the record simply did not support the university's claim that giving a preference to candidates of particular racial or ethnic groups would

---

[63] *See id.* at 317 ("In such an admissions program, race or ethnic background may be deemed a 'plus' in a particular applicant's file, yet it does not insulate the individual from comparison with all other candidates for available seats. . . . In short, an admissions program operated in this way is flexible enough to consider all pertinent elements of diversity in light of the particular qualifications of each applicant, and to place them on the same footing for consideration, although not necessarily according them the same weight.") (footnote omitted). A candidate's racial or ethnic minority status alone would not, in Powell's opinion, necessarily promote the goal of classroom diversity. Instead, an admissions program, in Powell's view, should further its diversity goals by individually evaluating and selecting candidates with "a far broader array of qualifications and characteristics of which racial or ethnic origin is but a single though important element." *Id.* at 315.

[64] *Id.* at 313. Justice Powell went on to acknowledge, however, that "even at the graduate level, our tradition and experience lend support to the view that the contribution of diversity is substantial." *Id.*

[65] *Id.* at 314 (footnote omitted). Justice Powell added that "[e]thnic diversity, however, is only one element in a range of factors a university may properly consider in attaining the goal of a heterogeneous student body." *Id.*

[66] *Id.* at 310–11. No other justices joined the portion of the Powell opinion endorsing classroom diversity as a rationale justifying the use of race in admissions programs. Justice Powell's opinion was the only opinion to recognize classroom diversity as a compelling governmental interest that would justify the use of race as a factor in higher education admissions. The remaining justices in the highly splintered opinion who supported the concept of affirmative action did so on the grounds that the practice compensates for the lingering effects of slavery and segregation. *Id.* at 325.

advance this goal.[67] Today, this argument in support of race conscious admissions rests on a far more developed record. Recent research evaluating the preferences of URM physicians to provide care to underserved populations now strongly supports the argument that minority physicians are more likely to choose to provide care to minority patients and that these patients prefer to receive care from physicians of the same race or ethnicity.[68]

In two federal decisions following *Bakke*, the Fifth and Ninth Circuits disagreed about whether to embrace Justice Powell's reasoning[69] and the Supreme Court ultimately addressed the resulting circuit split in the Michigan litigation. In *Gratz* and *Grutter*, white applicants who were denied admission to the University of Michigan's undergraduate and law programs respectively challenged the university's use of racial classifications in admissions, claiming that the policies violated both the Equal Protection Clause of the Fourteenth Amendment as well as Title VI of the Civil Rights Act of 1964.[70] The University of Michigan's law school admissions program, as described in *Grutter*, involved individual evaluation of each applicant in order to admit a class with a "critical mass" of students with diverse viewpoints and experiences and of diverse race and ethnicity.[71]

In *Grutter*, a bare majority of the Court embraced the concept of classroom diversity as a justification for a narrowly tailored race conscious admissions program[72] and provided some additional clarity about the

---

[67] Justice Powell noted that "[p]etitioner simply has not carried its burden of demonstrating that it must prefer members of particular ethnic groups over all other individuals in order to promote better health-care delivery to deprived citizens." *Id.* at 311; *see also id.* at 310 n.46 (noting that the "only evidence in the record with respect to such underservice is a newspaper article").

[68] *See infra* notes 135–41 and accompanying text.

[69] *See* Hopwood v. Texas, 78 F.3d 932, 944–45 (5th Cir. 1996) (declining to adopt Justice Powell's reasoning about the value of diversity in the classroom); Smith v. Univ. of Wash. Law Sch., 233 F.3d 1188, 1196–1201 (9th Cir. 2000) (adopting Justice Powell's arguments from *Bakke*).

[70] Gratz v. Bollinger, 539 U.S. 244, 252, 268–75 (2003) (striking down Michigan's undergraduate admissions policy by a vote of six to three based on its conclusion that the policy failed the narrow tailoring test); Grutter v. Bollinger, 539 U.S. 306, 317 (2003) (upholding Michigan's law school policy of using race as a factor in admissions decisions). For a lively and accessible account of the Michigan litigation, see generally GREG STOHR, A BLACK AND WHITE CASE: HOW AFFIRMATIVE ACTION SURVIVED ITS GREATEST LEGAL CHALLENGE (2004).

[71] *See Grutter*, 539 U.S. at 314–16 (explaining that "[t]he policy does not restrict the types of diversity contributions eligible for 'substantial weight' in the admissions process, but . . . does, however, reaffirm the Law School's longstanding commitment to 'one particular type of diversity,' that is, 'racial and ethnic diversity with special reference to the inclusion of students from groups which have been historically discriminated against, like African Americans, Hispanics and Native Americans, who without this commitment might not be represented in our student body in meaningful numbers'") (citation omitted).

[72] This Article does not address the complex issue of whether particular race-conscious admissions strategies satisfy the constitutional requirement of narrow tailoring as laid out in *Grutter*. *See id.* at 326–36 (providing framework for analyzing whether use of race is narrowly tailored). Instead, this Article focuses on the unique nature and implications of the diversity rationale in the specific context of medical education.

diversity rationale. Justice O'Connor, writing the opinion for a five-justice majority, made several separate points about the operation of diversity within the university classroom, two of which deserve emphasis here. Not surprisingly, she confined her consideration of the value of the classroom diversity to the law school context. First, Justice O'Connor endorsed Justice Powell's views about the value of classroom diversity as a compelling governmental interest,[73] noting that a mix of students with varying backgrounds and experiences promotes stimulating intellectual discussion and exchange of viewpoints, and shared understanding of different races and cultures.[74] Second, she observed that graduation from an elite law school enhances the graduate's chances of active participation in public life and in positions of power in government, Congress, and judgeships.[75] Essentially, as commentators have noted, diversity in the classroom serves two distinct purposes. From an interpersonal relations perspective, the interaction of students of different races promotes interracial understanding, and from a utilitarian perspective, it creates a graduating body of students who are prepared to succeed in an increasingly diverse global economy and society.[76]

After concluding that classroom diversity constitutes a compelling state interest in legal education, Justice O'Connor next considered whether the law school's admissions program was narrowly tailored to promote that interest.[77] As Justice O'Connor explained, the law school used a highly

---

[73] *Id.* at 328.

[74] The implication is that the value of diversity is a two-way street—that both minority and white students experience a benefit in the exchange of differing viewpoints and experiences. *See id.* at 330 (agreeing with the District Court and amici that the law school's admissions policy "promotes cross-racial understanding, helps to break down racial stereotypes," that debate in racially diverse classrooms "is livelier, more spirited, and simply more enlightening and interesting," and that "student body diversity promotes learning outcomes, and better prepares students for an increasingly diverse workforce and society, and better prepares them as professionals") (citations omitted).

[75] *See id.* at 332–33 (noting that "universities, and in particular, law schools, represent the training ground for a large number of our Nation's leaders" and that "[i]n order to cultivate a set of leaders with legitimacy in the eyes of the citizenry, it is necessary that the path to leadership be visibly open to talented and qualified individuals of every race and ethnicity"); *see also* Sherrilyn A. Ifill, *Racial Diversity on the Bench: Beyond Role Models and Public Confidence*, 57 WASH. & LEE L. REV. 405, 405, 479–81 (2000) (arguing that "[d]iversity on the bench can enrich judicial decision-making by including a variety of voices and perspectives in the deliberative process"); Charles Lane, *In Court's Ruling, a Nod to Notion of a Broader Elite*, WASH. POST, June 25, 2003, at A01, *available at* LEXIS, News Library, WPOST File (summarizing Justice O'Connor's observations that "admission to selective institutions is a prelude to power, and that a racially and ethnically mixed leadership cadre is essential to the public's support of American institutions" and explaining that the opinion demonstrates how arguments in the affirmative action debate have evolved since the 1960s when discussion centered primarily around efforts to "address the legacy of slavery and segregation").

[76] *See* Michelle Adams, *Shifting Sands: The Jurisprudence of Integration Past, Present, and Future*, 47 HOW. L.J. 795, 822–25 (2004) (describing and commenting on Justice O'Connor's understanding of the benefits of classroom diversity); Goodwin Liu, *Affirmative Action in Higher Education: The Diversity Rationale and the Compelling Interest Test*, 33 HARV. C.R.-C.L. L. REV. 381, 383–89 (1998) (articulating why educational diversity is a compelling interest based on the equal protection doctrine).

[77] *See Grutter*, 539 U.S. at 326–27 (explaining that "[a]lthough all governmental uses of race are

individualized evaluation of each applicant,[78] considered race as one of many factors that might promote diversity,[79] considered minority applicants in competition with other applicants, and sought merely to achieve a "critical mass" of racially diverse students but did not have a specific percentage as its goal.[80] For these reasons, Justice O'Connor and the majority concluded that the program appropriately considered race and ethnicity and was narrowly tailored to promote the goal of achieving a diverse classroom experience for its students.[81] Although Justice Kennedy dissented in the case, arguing that the University of Michigan School of Law's particular admissions scheme did not satisfy the narrow tailoring requirement, he agreed with the idea that a diversity rationale could serve as a basis for race-conscious admissions policies.[82]

In its most recent term, the Court once again addressed the question of racial diversity in education, this time in the context of public elementary and secondary schools. In *Parents v. Seattle School District 1*, Chief Justice Roberts, writing for a divided Court, concluded that school district plans that assign students to schools based on race violate the Equal Protection Clause,[83] despite the fact that the school assignment plans were

---

subject to strict scrutiny, not all are invalidated by it").

[78] *Id.* at 337.

[79] *See id.* at 338 (explaining that a student might also be considered likely to contribute to class diversity if he or she has, for example, traveled extensively, speaks several languages, or has overcome personal hardship or had a successful career in another field prior to applying to law school and adding that the record demonstrates that the law school actually accords substantial weight to factors other than minority status).

[80] *See id.* at 334–36 (explaining that the program does not appear to be an inappropriate attempt at "racial balancing," particularly because the percentage of admitted minority students varies significantly from one year to the next).

[81] *Id.* at 334. In *Gratz*, Chief Justice Rehnquist, joined by five other members of the Court, acknowledged the conclusion in *Grutter* that classroom diversity could constitute a compelling governmental interest. Gratz v. Bollinger, 539 U.S. 244, 268 (2003). Nevertheless, the majority concluded that Michigan's undergraduate admissions procedure was not narrowly tailored to promote that interest and that it therefore violated the Equal Protection Clause and Title VI. *See id. at* 275–76 (holding that "because the University's use of race in its current freshman admissions policy is not narrowly tailored to achieve respondents' asserted compelling interest in diversity, the admissions policy violates the Equal Protection Clause of the Fourteenth Amendment" and further concluding that the policy violates Title VI for the same reasons) (citation omitted).

[82] *See Grutter*, 539 U.S. at 387–89. The other two dissenters, Justices Scalia and Thomas, concluded that the use of diversity to justify race-conscious university admissions policies was unconstitutional. *Id.* at 346–351. The myriad complexities involved in determining whether a particular university's version of race-conscious admissions satisfies the narrow tailoring requirement are outside the scope of this Article.

[83] Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1, *together with* Meredith v. Jefferson County Bd. of Educ., 127 S. Ct. 2738, 2767–68 (2007); *see also* Robert Barnes, *Divided Court Limits Use of Race by School Districts*, WASH. POST, June 29, 2007, at A01, *available at* LEXIS, News Library, WPOST File (summarizing the opinions of the majority and the dissent); Linda Greenhouse, *Justices, Voting 5-4, Limit the Use of Race in Integration Plans*, N.Y. TIMES, June 29, 2007, at A1, *available at* LEXIS, News Library, NYT File (reporting on the Supreme Court's decision to invalidate school-assignment programs in Seattle and Louisville). The school assignment plans in question both utilized specific percentage goals for minority representation in individual schools and used student race as a factor in deciding where individuals could attend school within their respective districts. *See*

attempting to promote racial integration. Interestingly, Justice Kennedy, concurring in part and concurring in the judgment, argued that the plurality opinion inappropriately dismissed the government's legitimate interest in creating a diverse student body, suggesting that school districts could "adopt general policies to encourage a diverse student body . . . without treating each student in a different fashion solely on the basis of systematic, individual typing by race."[84] Almost immediately after the decision was announced, parent groups resurrected challenges to similar local school district policies. School assignment plans around the country designed to promote de facto desegregation now face renewed legal scrutiny.[85] In the wake of these recent decisions, it is difficult to predict how the newly constituted Court would rule on the diversity rationale in the higher education context, were they to revisit the issue.

The majority opinion in the school assignment cases, in distinguishing *Grutter*, treats the public school and higher education contexts differently, focusing primarily on the use of race for remedial purposes in public education but allowing for a separate consideration of the value of diversity in the higher education context.[86] Moreover, the race-conscious admissions program in *Grutter* evaluated each student individually and holistically rather than simply trying to balance the presence of different minority groups within the school. Nevertheless, it is troubling that the five-justice plurality refused to acknowledge the very different purposes that consideration of race promotes in these modern districting plans compared with the old use of race to segregate schools in the years before *Brown v. Board of Education* was decided. Whatever the eventual fallout, the decision in the school assignment cases signals a significant adverse shift in racial desegregation policy and a continued erosion of support for

---

Parents, 127 S. Ct. at 2749–50 (describing the school programs in more detail).

[84] *See Parents*, 127 S. Ct. at 2792 (Kennedy, J. concurring in part and concurring in the judgment). Justice Kennedy dissented in *Grutter*, but allowed for the appropriateness of considering race if the university's plan had met his standard of narrow tailoring when subjected to genuine strict scrutiny analysis. *See Grutter*, 539 U.S. at 387–89 (Kennedy, J., dissenting) (explaining that Justice Powell's position in *Bakke* "is based on the principle that a university admissions program may take account of race as one, nonpredominant factor in a system designed to consider each applicant as an individual" and that, had the majority in evaluating the *Grutter* plan genuinely applied strict scrutiny, it would have invalidated the plan).

[85] *See, e.g.*, April Yee, *Challenge to Lynn's Race Policy is Revived: High Court Buoys Foes of School Transfer Rule*, BOSTON GLOBE, July 5, 2007, at A1, *available at* LEXIS, News Library, BGLOBE File (noting that the Supreme Court's decision will have an impact on approximately twenty school-assignment programs in Massachusetts alone); *see also* Amit R. Paley & Brigid Schulte, *Court Ruling Likely to Further Segregate Schools, Educators Say*, WASH. POST, June 30, 2007, at A04, *available at* LEXIS, News Library, WPOST File (noting that approximately 1000 of the 15,000 school districts nationwide use race as a factor in school assignment).

[86] *See Parents*, 127 S. Ct. 2751–54. Chief Justice Roberts explicitly declined to reverse the holding in *Grutter*, explaining that there are "considerations unique to institutions of higher education" which make it more appropriate to consider race as part of a "holistic review" of an applicant's request for admission. *Id.* at 2753–54.

integration in this country which will undoubtedly have a negative impact on higher education as well.

IV. DIVERSITY IN THEORY AND IN PRACTICE: THE MEDICAL EDUCATION CONTEXT

The problem of achieving diversity is hardly unique to medical education. Administrators in other professional education contexts, such as law, struggle with some of the same issues. For example, in the past ten years, African American enrollment in law schools has declined, although Asian and Hispanic enrollment has grown,[87] and, as in medical education, law schools wrestle with controversial questions about the purposes of and appropriate means to achieve student body diversity.[88] The focus of the remainder of discussion on the role of diversity in medical education is not intended to diminish its importance in other contexts but rather to make the case for the uniqueness of the diversity rationale in medical education.

In the general affirmative action literature, the term "diversity" usually refers to racial and ethnic diversity with a particular emphasis on underrepresented races compared with population-wide percentages. In current discussions of "diversity" in medical education, much of the debate

---

[87] *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-07-314, HIGHER EDUCATION: ISSUES RELATED TO LAW SCHOOL ACCREDITATION, app. I, slide 11 (2007), *available at* http://www.gao.gov/new.items/d07314.pdf (showing a decline in African American enrollment from 8.1 percent in 1994–95 to 6.2 percent in 2005–06).

[88] The Department of Education (DOE) recently renewed the ABA's status as an accrediting body for law schools for eighteen months, instead of the usual five year term. The Bush Department of Education Tries to Gut Grutter Below the Radar Screen, http://www.michaeldorf.org/2007_07_01_archive.html (July 11, 2007, 07:18 EST). The move appears to result in part from the DOE's expressed concern that the ABA will evaluate law school compliance with its requirement of institutional commitment to faculty and student body diversity based on the results achieved and that this level of scrutiny in turn will encourage law schools to "employ race conscious admissions and hiring practices, including racial or ethnic quotas." U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 87, at app. I, slide 20; *see also* STANDARDS FOR THE APPROVAL OF LAW SCHOOLS, standard 212 (2007–2008), *available at* http://www.abanet.org/legaled/standards/standards.html (follow "Chapter 2: Organization and Administration" hyperlink) (requiring accredited law schools to take steps to achieve student and faculty diversity). The ABA has defended its diversity standard, which "only requires schools to demonstrate that they are reaching out to groups underrepresented in the legal profession" and has noted that quotas are not used. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 87, at app. I, slide 21; *see also* Gary Orfield & Dean Whitla, *Diversity and Legal Education: Student Experiences in Leading Law Schools, in* DIVERSITY CHALLENGED: EVIDENCE ON THE IMPACT OF AFFIRMATIVE ACTION 143, 145–51, (Gary Orfield & Michael Kurlaender eds., 2001) (describing litigation regarding affirmative action in higher education and its impact on legal education); *see also generally* T. Alexander Aleinikoff, *A Case for Race-Consciousness*, 91 COLUM. L. REV. 1060, 1060–62 (1991) (providing an overview of Supreme Court jurisprudence on affirmative action and the "colorblind" concept and their implications for progress in race relations); Adam Blumenkrantz et al., *Affirming Michigan's Action:* The Michigan Journal of Race and Law's *Response to Dr. Carcieri's* "Grutter v. Bollinger *and Civil Disobedience*," 31 U. DAYTON L. REV. 381, 382–83 (2005) (criticizing the rationale of looking at the law in a colorblind manner); Elizabeth Rindskopf Parker & Sarah E. Redfield, *Law Schools Cannot Be Effective in Isolation*, 2005 BYU EDUC. & L.J. 1, 2–5 (discussing how to promote diversity through education reform).

centers around racial and ethnic diversity, particularly the under-representation of four minority groups in medical school: African Americans, Mexican Americans, Native Americans, and mainland Puerto Ricans.[89] In addition to acknowledging the impact of racial diversity in the classroom, it is worth adding that religious, socio-economic, and even political viewpoint diversity can play an important role in medical training and in the provision of quality medical care.[90]

A. *History and Progress*

Medical educators committed to improving the racial and ethnic diversity among physicians have made notable progress in the last forty years, and although the number of African American physicians increased by 50% from 1980 to 2004[91] African Americans remain underrepresented in the physician workforce. In the 1968–69 academic year, African Americans comprised only 2.2% of the 35,800 total students enrolled in medical schools.[92] Fifty-eight percent of African American students at that time attended either Howard or Meharry, two historically black medical

---

[89] The term "underrepresented minority" (URM) was adopted by the Association of American Medical Colleges in the 1970s to refer to these four groups. Jordan J. Cohen, *The Consequences of Premature Abandonment of Affirmative Action in Medical School Admissions*, 289 J. AM. MED. ASS'N 1143, 1145 (2003). The issue of gender representation in medical education is outside the scope of this Article, though it is worth noting that applications of white males to medical school are generally on the decline, while applications of females are rising. *See* Richard A. Cooper, *Medical Schools and Their Applicants: An Analysis*, 22 HEALTH AFF. 71, 77–78 (2003) (providing statistical evidence that the number of female medical school applicants continue to grow while the number of male medical school applicants has declined since the 1970s).

[90] *See infra* notes 147–51 and accompanying text. The concept of diversity in education, if its proponents truly intend to foster a community of different ideas and perspectives, should encompass more than simply racial diversity. *Cf.* Abigail Thernstrom & Stephan Thernstrom, *Secrecy and Dishonesty: The Supreme Court, Racial Preferences, and Higher Education*, 21 CONST. COMMENT. 251, 262–63 (2004) (arguing that universities with race-conscious admissions programs do not utilize similar preferences for Christian fundamentalists, orthodox Jews, Muslims, or other groups with distinct viewpoints and that, for this reason, the definition of diversity is "remarkably narrow" and to some extent dishonest about the motives behind racial preferences).

[91] In 1980, 12,916 of graduating medical students were white compared with 336 Asian graduates, 704 African American graduates, 473 Hispanic/Latino graduates, and 40 Native American graduates. By 2004, there were 11,117 white, 3554 Asian, 1063 African American, 1050 Hispanic/Latino, and 112 Native American graduates. ASS'N OF AM. MED. COLLEGES, DIVERSITY IN THE PHYSICIAN WORKFORCE: FACTS AND FIGURES 2006, at 22 (2006), *available at* https://services.aamc.org/Publications/showfile.cfm?file=version79.pdf&prd_id=161&prv_id=191&pdf_id=79; *see also* Arnold M. Epstein, *Health Care in America—Still Too Separate, Not Yet Equal*, 351 NEW ENG. J. MED. 603, 603 (2004) (noting growth in the proportion of blacks who work as professionals, including physicians); H. W. Nickens et al., *Project 3000 by 2000—Racial and Ethnic Diversity in U.S. Medical Schools*, 331 NEW ENG. J. MED. 472, 472–75 (1994) (providing data from the mid-1960s through 1993 and describing the enrollment in medical schools in the mid-1960s compared with the mid-1990s, noting that "[a]lthough women have made steady progress toward equitable representation, the enrollment gains for members of racial and ethnic minority groups have been sporadic and uneven").

[92] Native Americans comprised .02% of the enrollment that year, Mexican Americans .16%, and mainland Puerto Ricans .01%. CURTIS *supra* note 52, at xiv (citing data from CHARLES E. ODEGAARD, MINORITIES IN MEDICINE: FROM RECEPTIVE PASSIVITY TO POSITIVE ACTION, 1966–76, 31 (1977)).

schools.[93] In the following eight years, medical schools made significant progress toward the goal of integrating the profession. By academic year 1975–76, 6.2% of the 35,800 total medical students were African American.[94] At this point, medical schools had a total underrepresented minority (URM) enrollment of 8.1%, but only 12.45% of these students were enrolled at Howard or Meharry.[95]

Certain minority groups currently remain underrepresented in medical schools.[96] The most recent available figures indicate that in 2004, 6.5% of U.S. medical school graduates were African American and 6.4% were of Hispanic origin.[97] Additionally, African Americans then comprised 3.3% of the current physician workforce and Hispanics 2.8%.[98] As a point of comparison, African Americans comprise approximately 13% of the total U.S. population,[99] while Hispanics also comprise almost 13% of the population.[100] The attacks on affirmative action described above have exerted a direct and marked impact on URM enrollment. In 1995, African American enrollment peaked at 9% with Hispanic enrollment peaking at 7.2% in 1996.[101] During the same period, the Fifth Circuit issued an opinion prohibiting public universities from considering race in admissions,[102] and Proposition 209 was passed in California, banning the

---

[93] *See* CURTIS *supra* note 52, at 16 ("For all practical purposes, these two schools were set aside for Blacks, at a time when all other medical schools did not accept, or admitted only token numbers of, Blacks.").

[94] *Id.* at xiv (noting that Native Americans comprised .03% of the enrollment that year, Mexican Americans 1.3%, and mainland Puerto Ricans .4%).

[95] *Id.* The figures on URM representation vary slightly depending on their source and how the calculations are done. Another source citing figures for 1978 claims that enrollment of URM students stood at 7.9% and that 5.7% of medical students in that year were African Americans. *See* CURTIS, *supra* note 52, at 29.

[96] *See* Stanley S. Bergen, Jr., *Underrepresented Minorities in Medicine*, 284 J. AM. MED. ASS'N 1138, 1138 (2000) (noting that the number of underrepresented minorities accepted to medical school continued to decline in the 1999–2000 academic year); ASS'N OF AM. MED. COLLEGES, MINORITIES IN MEDICAL EDUCATION: FACTS AND FIGURES 2005, at 27 (2005), *available at* http://services.aamc.org/publications/showfile.cfm?file=version53.pdf&prd_id=1338&prv_id=1548pdf_id=53 [hereinafter FACTS AND FIGURES 2005] (showing that in 2004, Asian, Hispanic, African American and Native American medical students represented only 32.4% of medical school matriculants nationwide).

[97] FACTS AND FIGURES 2005, *supra* note 96, at 27.

[98] ASS'N OF AM. MED. COLLEGES, DIVERSITY IN THE PHYSICIAN WORKFORCE: FACTS AND FIGURES 2006, at 15 (2006), *available at* http://services.aamc.org/publications/showfile.cfm?file=version79.pdf&prd_id=161&prv_id=191&pdf_id=79.

[99] *See* U.S. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 16 (2000), *available at* http://www.census.gov/prod/2001pubs/statab/sec01.pdf (estimating the black population at 12.8% in 2000 and 13.1% in 2005).

[100] *See id.* at 17 (estimating the Hispanic origin population of 11.8% in 2000 and 13.3% in 2005).

[101] Jordan J. Cohen et al., *The Case for Diversity in the Health Care Workforce*, HEALTH AFF. Sept.–Oct. 2002, at 90, 98; *see also* SUSAN WELCH & JOHN GRUHL, AFFIRMATIVE ACTION AND MINORITY ENROLLMENTS IN MEDICAL AND LAW SCHOOLS 107–32 (1998) (reviewing data from the late 1960s to 1987 and describing the limited impact of *Bakke* on minority enrollment in medical and law schools).

[102] Hopwood v. Texas, 78 F.3d 932, 962 (5th Cir. 1996).

use of race in the public universities admissions. Not surprisingly, the percentage of URM medical students began a slow decline.[103]

A portion of the underrepresentation problem stems from the under-supply of minority students from public schools who are academically prepared to succeed as undergraduates and thus are able to apply successfully to medical schools.[104] The after-effects of two centuries of racial discrimination, higher rates of poverty, and lower educational attainment in families of URM public school students reduces the likelihood that these students will have the opportunity to prepare for and successfully apply to medical school.[105] As one commentator noted, "[m]edical schools quite properly will admit only those who are almost certain to graduate, and the substandard educational opportunity available to Black youngsters constricts the pipeline."[106] Public schools in the United States are re-segregating, despite efforts by many school systems to keep them integrated,[107] and the Supreme Court's school assignment decision from last term will likely hasten this process.[108] Moreover,

---

[103] *See* Cohen et al., *supra* note 101, at 98 (adding that if the percentage of URM students had remained at its 1996 peak, there would be at least 1400 additional URM physicians in the workforce).

[104] CURTIS, *supra* note 52, at 1. In the words of President Lyndon Johnson, "You do not take a person, who for years, has been hobbled by chains and liberate him, bring him up to the starting line of a race and then say, 'You are free to compete with all the others,' and still justly believe that you have been completely fair." *See* Leslie Yalof Garfield, *Back to* Bakke*: Defining the Strict Scrutiny Test for Affirmative Action Policies Aimed at Achieving Diversity in the Classroom*, 83 NEB. L. REV. 631, 632 n.1 (2005) (citing Lyndon B. Johnson, *To Fulfill These Rights*, Speech at Howard University (June 4, 1965)).

[105] Cohen, *supra* note 89, at 1145. More broadly, opportunity for high quality education is frequently related to income. The African American middle class is proportionately smaller than the white middle class. *See also* BOWEN & BOK, *supra* note 6, at 11 (explaining that African Americans are half as likely as whites to earn $50,000 per year and that even the highest earning African Americans have less than one quarter of the net financial assets as whites with similar incomes).

[106] CURTIS, *supra* note 52, at 1.

[107] *See* GARY ORFIELD & SUSAN E. EATON, DISMANTLING DESEGREGATION: THE QUIET REVERSAL OF *BROWN V. BOARD OF EDUCATION* 53–69 (1996) (noting that in many cities overall segregation grew in the late 1980s and 1990s); *see also* ERICA FRANKENBERG ET AL., A MULTIRACIAL SOCIETY WITH SEGREGATED SCHOOLS: ARE WE LOSING THE DREAM? 5 (2003) *available at* http://www.civilrightsproject.ucla.edu/research/reseg03/AreWeLosingtheDream.pdf (commenting on the "emergence of a substantial group of American schools that are virtually all non-white, which we call apartheid schools. These schools educate one-sixth of the nation's black students and one-fourth of black students in the Northeast and Midwest. These are often schools of enormous poverty, limited resources, and social and health problems of many types are concentrated."); Lawrence, *supra* note 6, at 944–47 & n.68 (describing the de facto segregation of public schools, and providing statistics on California schools that suggest what Lawrence calls "hypersegregation," i.e. 40% of Latino students and 35% of African American students in California are enrolled in public schools that are populated by 90% or more minority students).

[108] *See* Adam Liptak, *The Same Words, but Differing Views*, N.Y. TIMES, June 29, 2007, at A24 *available at* LEXIS, News Library, NYT File (quoting observers who expect that "most prudent school districts would shy from any use of race in assigning students for fear of costly and disruptive litigation"); *see also* Tamar Lewin, *Across U.S., a New Look at School Integration Efforts*, N.Y. TIMES, June 29, 2007, at A25, *available at* LEXIS, News Library, NYT File (noting that, although the decision does not prohibit school districts altogether from taking race into account in school assignment, some districts are already considering alternative race-neutral criteria such as socioeconomic status to promote diversity).

African Americans and Hispanics have lower rates of high school graduation than whites,[109] making these minority groups statistically less likely to attend college programs that will prepare them for medical school.[110] Thus, the pool of URM applicants to medical schools who possess the academic credentials to compete successfully with other applicants remains comparatively small.[111]

Some commentators condemn affirmative action programs based on the belief that such programs admit minority candidates whose education has not adequately prepared them for the rigors of medical school,[112] and urge continued funding of outreach programs designed to intervene earlier in the educational process in order to increase the pool of qualified minority candidates for medical school.[113] Programs to improve preparation for medical school undoubtedly facilitate the academic success of under-represented minorities and, ultimately, will increase the numbers of minority physicians.[114] At least for now, however, it seems unlikely that these programs alone will prove effective in ensuring a critical mass of

---

[109] Cooper, *supra* note 89, at 79.

[110] *See* NAT'L CENTER FOR ED. STATISTICS, U.S. DEPT. OF ED., GENDER DIFFERENCES IN PARTICIPATION AND COMPLETION OF UNDERGRADUATE EDUCATION AND HOW THEY HAVE CHANGED OVER TIME 29 (2005).

[111] *See* Cooper, *supra* note 89, at 78–79.

[112] *See* SALLY SATEL, PC, M.D.: HOW POLITICAL CORRECTNESS IS CORRUPTING MEDICINE, 185–86 (2000) (reviewing evidence suggesting that the admission of underrepresented minority students with substantially weaker academic preparation into medical schools leads to disproportionately higher rates of academic difficulty for these students). *But see* Ethan Bronner, *Study of Doctors Sees Little Effect of Affirmative Action on Careers*, N.Y. TIMES, Oct. 8, 1997, at A1 *available at* LEXIS, News Library, NYT File (finding that students admitted to the U.C. Davis Medical School under special race preferences finished with academic records, and ultimately professional careers, similar to those students admitted on academic merit alone).

[113] SATEL, *supra* note 112, at 189–90.

[114] *See, e.g.*, CURTIS, *supra* note 52, at 36–39 (describing Cornell's Summer program and its success in preparing pre-med minority students for the medical school application process); Jordan J. Cohen & Ann Steinecke, *Building a Diverse Physician Workforce*, 296 J. AM. MED. ASS'N 1135, 1135 (2006) (stating that Grumbach and Chen's article "confirms that postbaccalaureate programs are an effective means for increasing minority . . . students' acceptance to medical schools"); Kevin Grumbach & Eric Chen, *Effectiveness of University of California Postbaccalaureate Premedical Programs in Increasing Medical School Matriculation for Minority and Disadvantaged Students*, 296 J. AM. MED. ASS'N 1079, 1079 (2006) (finding such programs highly effective); *see also* Joel C. Cantor et al., *Effect of an Intensive Educational Program for Minority College Students and Recent Graduates on the Probability of Acceptance to Medical School*, 280 J. AM. MED. ASS'N 772, 775–76 (1998) (evaluating the effectiveness of a minority medical education program and concluding that participation in such a program significantly increases the participant's likelihood of being accepted to an allopathic medical school); *see also* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-07-137, HEALTH CAREERS OPPORTUNITY PROGRAM: PROCESS FOR AWARDING COMPETITIVE GRANTS INCLUDED INDEPENDENT REVIEW 1 (2007), *available at* www.gao.gov.new.items/d07137.pdf (describing a grant program administered under title VII of the Public Health Service Act which provides grants to medical schools to assist disadvantaged students in preparing for medical school and other health professional training). In a similar vein in the law school context, in order to promote diversity more actively, the ABA has implemented "pipeline" programs to generate interest in law careers and to provide opportunities for URM students to prepare for law school admission. ABA, Presidential Advisory Council on Diversity in the Profession, www.abanet.org/op/councilondiversity (last visited Nov. 1, 2007).

URM students in medical schools.[115] Outreach programs should be used to enhance the impact of affirmative action in medical school admissions, but, at this point, affirmative action remains a necessary and appropriate tool promote diversity in the medical school classroom and ultimately in the physician work force.[116]

Nevertheless, despite the Court's holding in *Grutter*, some commentators continue to argue that the basic constitutional principle of racial equality and the concurrent requirement of strict scrutiny create a strong presumption against the use of racial classifications.[117] Given the controversy surrounding affirmative action, race-neutral alternatives to affirmative action, such as socio-economic diversity, continue to receive serious consideration and such alternatives undoubtedly serve as appropriate adjuncts to race preferences.[118] It is not clear, however, whether using exclusively race-neutral preferences will allow for the admission of a "critical mass" of URM students in medical schools. The broader debate about the merits of affirmative action deserves continued attention and will, it is hoped, eventually become moot if the achievement gap between the races diminishes. The remainder of this Article will examine how diversity, whether achieved through affirmative action or race-neutral means, or both, enhances the quality of medical education and

---

[115] *See* FACTS AND FIGURES 2005, *supra* note 96 (concluding that, although the numbers of URM applicants and matriculants to medical school have increased in recent years, "there remain fundamental structural problems in our nation's education system that impede efforts to increase diversity in medical education"); INSTITUTE OF MEDICINE, IN THE NATION'S COMPELLING INTEREST: ENSURING DIVERSITY IN THE HEALTH-CARE WORKFORCE 3–4, 12 (Brian D. Smedley et al eds., 2004) (explaining that "[t]he 'supply' of URM students who are well-prepared for higher education and advanced study in health professions fields has therefore suffered" and urging that health professions education bodies "more effectively encourage health professions schools to recruit URM students . . . and to develop an institutional climate that encourages and sustains the development of a critical mass of diversity").

[116] *See* Cohen, *supra* note 89, at 1147–48 (evaluating admissions data from 2001 and concluding that, absent the consideration of URM race as a factor, the number of URM students accepted to medical school would drop by seventy percent); *see also* CURTIS, *supra* note 52, at 13 (explaining that the concept of affirmative action "is based on the premise that relief from illegal racial discrimination is not enough to remove the burden of second-class citizenship from Blacks and other underrepresented minority groups in the United States . . . [and] [a]ffirmative action, aided by the . . . government, is therefore both justified and required to fulfill the objective of equal access").

[117] *See, e.g.*, David Crump, *The Narrow Tailoring Issue in the Affirmative Action Cases: Reconsidering the Supreme Court's Approval in* Gratz *and* Grutter *of Race-Based Decision-Making by Individualized Discretion*, 56 FLA. L. REV. 483, 485 (2004) (characterizing such classifications as "limited" in use); Gail L. Heriot, *Strict Scrutiny, Public Opinion, and Affirmative Action on Campus: Should the Courts Find a Narrowly Tailored Solution to a Compelling Need in a Policy Most Americans Oppose?*, 40 HARV. J. ON LEGIS. 217, 220–21 (2003) (noting the difficulty that race-based classifications have in passing the strict scrutiny standard).

[118] Still, commentators who suggest that socioeconomic status alone should serve as the relevant factor in seeking to diversify the student population in higher education fail to recognize that race remains relevant for now in its impact on preparation for and opportunity in higher education. *See* Eugene Robinson, *A Question of Race Vs. Class; Affirmative Action for the Obama Girls*, WASH. POST, May 15, 2007, at A15, *available at* LEXIS, News Library, WPOST File (observing that "diversity is a process, not a destination. We have to keep working at it").

ultimately the quality of care for patients of color.

B. *The Value of Diversity in Medical Education and Beyond*

In their highly influential book on race preferences in university admissions, William Bowen and Derek Bok make a compelling case, using data from a forty-year longitudinal study on African American and white university students, for the value of diversity as a justification for the continued use of affirmative action.[119] Other data supports the general value of diversity across all types and sizes of colleges and universities.[120] But, as Bowen and Bok have observed, "one problem with much of the debate over affirmative action is that it lumps together a large number of highly disparate areas and programs, ranging from the awarding of contracts to minority-owned businesses to . . . the admissions policies of colleges and universities."[121] Certain arguments in support of affirmative action to achieve diversity in business, for example, may be less persuasive in a different setting such as higher education.

Even within the context of higher education, diversity serves different functions in various educational settings. The learning experience for

---

[119] *See generally* BOWEN & BOK, *supra* note 6. Of course, attending racially and culturally diverse primary and secondary schools helps to promote understanding and provides a foundation for additional learning about these issues during higher education. *See* BEVERLY DANIEL TATUM, CAN WE TALK ABOUT RACE? 20 (2007) (explaining that "white children will need to be in schools that are intentional about helping them understand social justice issues like prejudice, discrimination, and racism, empowering them to think critically about the stereotypes to which they are exposed in the culture").

[120] The polling research on the impact of student diversity demonstrates its value as well as the continued ambivalence about race on college campuses:

> University administrators and faculty members talk endlessly about the value of student diversity, and efforts have been made to acquire supportive data. One study involving data from a longitudinal survey of 25,000 students at 159 colleges and universities found that white college students reported increased satisfaction with college when they participated in cross-cultural undertakings (e.g., taking ethnic studies courses, and socializing with members of other races). At the same time, researchers found that increasing the number of minorities on campus led to a somewhat lessened sense of community on the part of white students. A 1999 Gallup Poll survey of the law schools at Harvard and the University of Michigan (sponsored by the Harvard Civil Rights Project and covering 1,820 students or 81% of the law school enrollees at those campuses) reported that nearly 65% of the respondents said that ethnic and racial diversity in their classes improved discussion, and 87% said they changed their civil rights attitudes because of contacts with students of varied backgrounds. However, a 1997 poll of 530 Harvard undergraduates . . . found that 58% of the respondents reported that a significant amount of racial segregation existed on that campus.

SAMUEL LEITER & WILLIAM M. LEITER, AFFIRMATIVE ACTION IN ANTIDISCRIMINATION LAW AND POLICY: AN OVERVIEW AND SYNTHESIS 151 (2002).

[121] BOWEN & BOK, *supra* note 6, at xxv; *see also* Michael Selmi, *The Facts of Affirmative Action*, 85 VA. L. REV. 697, 729–31 (1999) (reviewing WILLIAM G. BOWEN & DEREK BOK, THE SHAPE OF THE RIVER: LONG-TERM CONSEQUENCES OF CONSIDERING RACE IN COLLEGE AND UNIVERSITY ADMISSIONS (1998)) (discussing the limitations of the diversity rationale while recognizing its value in higher education).

undergraduates, law students, and medical students, for example, differs significantly because the purpose of these programs and the eventual occupations of their participants differ. The educational stakes in medical training are enormous; as in other graduate professional programs, all members of a racially and otherwise diverse medical school class can potentially benefit from the experiences and attitudes of their peers. In medicine, however, this education also directly benefits the patients to whom these physicians provide care. As explained below, there is inextricable connection between physician training and successful communication with patients of different races and cultures, and a connection between communication, eradicating racial biases and stereotypes, and improved quality of care. Classroom diversity plays an essential role in promoting these goals in medical education and must, for now, be continued support through the use of carefully considered race-conscious admissions process.

Consider in comparison the law or business school contexts. Although a diverse class undoubtedly enhances the learning process for students in such programs,[122] the stakes after graduation may be lower. For better or worse, many attorneys or MBAs will enter practices or businesses where they will encounter few minority clients, though issues of cultural competence in lawyers have attracted comment as part of the discourse about how lawyers can provide skilled and effective representation.[123] By

---

[122] *See* David Dominguez, *Beyond Zero-Sum Games: Multiculturalism as Enriched Law Training for All Students*, 44 J. LEGAL EDUC. 175, 196–97 (1994) (maintaining that diversity in the classroom teaches students to overcome, racism, sexism, and other cultural conflicts); Roscoe C. Howard, Jr., *Getting It Wrong:* Hopwood v. Texas *and Its Implications for Racial Diversity in Legal Education and Practice*, 31 NEW ENG. L. REV. 831, 874–75 (1997) (arguing persuasively that "classroom diversity moves students and teachers forward as lawyers and contributing members of society" and providing examples of classroom exchanges in which diverse viewpoints facilitated better understanding of complex societal and legal issues).

[123] *See, e.g.*, Susan Bryant, *The Five Habits: Building Cross-Cultural Competence in Lawyers*, 8 CLINICAL L. REV. 33, 53–54 (2001) (observing that stereotyped thinking can harm clients' interests, particular the interests of poorer clients and clients of color); Bill Ong Hing, *Raising Personal Identification Issues of Class, Race, Ethnicity, Gender, Sexual Orientation, Physical Disability, and Age in Lawyering Courses*, 45 STAN. L. REV. 1807, 1809–10 (1992–93) (describing how lawyers who are cognizant of racial differences "may avoid making inappropriate assumptions and establishing false expectations," thereby improving attorney-client communication); Michelle S. Jacobs, *People from the Footnotes: The Missing Element in Client-Centered Counseling*, 27 GOLDEN GATE U. L. REV. 345, 394–95 (1997) (explaining that by enabling law students to become "self-aware" of certain personal prejudgments they possess, the level of cultural insensitivity toward the client may be reduced). The impact of a lawyer's race on his or her ability to represent a client of color continues to prompt heated debate. *See, e.g.*, Roland Acevedo et al., *Race and Representation: A Study of Legal Aid Attorneys and Their Perceptions of the Significance of Race*, 18 BUFF. PUB. INT. L.J. 1, 41–44 (1999–2000) (describing and discussing a small sample-size survey of legal aid attorney's views about the role of race in providing representation to their clients and concluding that minority attorneys were more likely to perceive their own minority race as an advantage in promoting quality communication with their minority clients); *see also* Michelle S. Jacobs, *Full Legal Representation for the Poor: The Clash Between Lawyer Values and Client Worthiness*, 44 HOW. L.J. 257, 262 (2001) (concluding "that the bar reflects the dominant societal view that poor people are unworthy" of representation); Kenneth P. Troccoli, *"I Want a Black Lawyer to Represent Me": Addressing a Black Defendant's Concerns with*

contrast, most physicians will care for some, if not many, patients whose race, ethnicity, religion, and educational level differs from their own, and the quality of care these patients receive can have a significant impact on their health and quality of life. In medical schools, a diverse class serves the interests of the future physicians themselves and, more importantly, their patients.

By definition, medical education requires student interaction that differs in kind from that experienced by undergraduates, law, or business students. In fact, some commentators have observed that the development of physicians' professionalism occurs mainly "outside the domain of the formal curriculum and that such learning involves indoctrination in the unwritten rules of . . . medical practice."[124] Because so much of medical professionalism centers around the physician's ability to communicate with the patient and because so many physicians provide care for patients whose backgrounds differ from their own, the informal learning that occurs in the interstices of the formal medical curriculum can only be enriched by the interaction of students with diverse backgrounds and experiences.[125] Medical students develop their professional selves through a complex process of acquiring values along with medical knowledge:

> It is not sufficient for students to acquire the knowledge, skills, and outward behavior necessary for practicing medicine. Being a physician—taking on the identity of a true medical professional—also involves a number of value orientations, including a general commitment not only to learning and excellence of skills but also to behavior and practices that are authentically caring.[126]

Being Assigned a White Court-Appointed Lawyer, 20 LAW & INEQ. 1, 3 (2002) (arguing that it is relatively difficult for an indignant black client to establish good rapport with a white attorney, thus creating an obstacle to effective representation).

[124] Frederic W. Hafferty, *Professionalism—The Next Wave*, 355 NEW ENG. J. MED. 2151, 2151 (2006). Some commentators on the value of diversity in education miss this point entirely, focusing on improvements in book learning among students in certain all-black schools and ignoring the more difficult to measure improvements in cultural understanding and tolerance. *See, e.g.*, Thomas Sowell, *Today's Lesson: 'Diversity,'* SPRINGFIELD REPUBLICAN, Dec. 13, 2006, at A11.

[125] *See* TATUM, *supra* note 119, at 106 (quoting Louis Menaud, "You cannot teach people a virtue by requiring them to read books about it. You can only teach a virtue by calling upon people to exercise it . . ." and adding that "[w]e must ask if our learning environments create opportunities for practicing the behaviors required in an effective democracy"); *cf.* Jeffrey F. Milem, *The Educational Benefits of Diversity: Evidence from Multiple Sectors*, *in* COMPELLING INTEREST: EXAMINING THE EVIDENCE ON RACIAL DYNAMICS IN COLLEGES AND UNIVERSITIES 126, 134–35 (Mitchell J. Chang et al. eds. 2003) (describing a well-established body of research that demonstrates that undergraduate education represents a critical stage in students' psychosocial development, including an understanding of ethics, values, and responsibilities).

[126] *See* Hafferty, *supra* note 124, at 2152 (adding that these "value orientations and motives are, in part, the product of professional learning and socialization, with medical schools and residency programs functioning as critical settings for the development of . . . the 'habit of professionalism' . . . . It is this underpinning that provides the necessary stability and generalizability . . . to step outside the

It is this aspect of professional education that deserves special notice in the context of medical education. Of course, all professional education (law, business, engineering) involves more than simply the acquisition of specialized knowledge. Most professionals in these disciplines acquire values and communication skills along with the rest of their training, but those acquired by future physicians possess a unique significance because they directly affect the physician-patient relationship and thus the patient's health and well-being.

The first four years of medical school are divided into two years of preclinical and two years of clinical training.[127] Medical educators explain that the entire training experience is designed to promote four inter-related goals: basic science and medical knowledge, basic skills such as performing a physical exam, attitudes and values such as professionalism, and a habit of lifelong learning which is necessary for physicians to keep abreast of evolving medical concepts and technologies.[128] Although much of the preclinical curriculum focuses on learning the basic science and principles of disease, medical students also begin, usually in a highly interactive format, to learn clinical practice skills such as learning to take patients' medical histories, and learning to perform basic procedures such as taking vital signs, and performing physical examinations.[129] Often, students practice on each other, or on volunteer actors who play the role of patients. During the following two clinical years, medical students gain experience in all of the major specialties, usually including internal medicine, surgery, pediatrics, obstetrics and gynecology, psychiatry, and neurology.[130] Exposure to these specialties through hospital and outpatient-based "clerkships" gives medical students the opportunity to work with qualified physicians as they learn about the more common

realm of textbook medical practice and confront situations of uncertainty and ambiguity") (footnotes omitted).

[127] Herbert Chase, *Medical School: An Overview if Medical School Education*, *in* THE YALE GUIDE TO MEDICAL CAREERS IN MEDICINE: THE HEALTH PROFESSIONAL 89, 89 (Robert M. Donaldson, Jr. et al. eds., 2003) [hereinafter THE YALE GUIDE]; *see also* Barbara Barzansky et al., *Educational Programs in US Medical Schools, 1999–2000*, 284 J. AM. MED. ASS'N 1114, 1117–18 (2000) (providing a detailed description of the medical school curriculum). After the four-year program, the vast majority of medical graduates go on to post-graduate residency programs which last for a minimum of three years, depending on specialty. *See* CHRISTINE H. MCGUIRE ET AL., HANDBOOK OF HEALTH PROFESSIONS EDUCATION (1983) (explaining that such residency programs had become quite common by 1960 and that the trend toward specialization arose in combination with the increasing availability of advanced medical technologies).

[128] MCGUIRE ET AL., *supra* note 127, at 24.

[129] *See id.* at 35–36 ("If the major teaching objective of the first two years in medical school is to have the students acquire the cognitive knowledge and symbolic logic necessary to comprehend illness as it occurs in Western industrialized societies, and if the objective of the transition course . . . is to have them acquire the skills necessary to gather clinical data, then the objective of the third-year clinical clerkships is to give the students the opportunity to practice and perfect their recently acquired skills.").

[130] *See id.* at 36.

diseases and conditions associated with each specialty and to develop more practical skills.[131] As students begin to participate in actual medical practice, ideally they will learn not only how to diagnose and treat a patient's illness, but also how to care for individuals based on each patient's particular personal environment, financial circumstances, religious beliefs, cultural concerns, and other relevant factors.[132]

In sum, the benefits of classroom diversity in medical schools extend far beyond the classroom. Ideally, the physician workforce will mirror the increasingly diverse society in which it practices. Obviously, training more minority applicants in medical schools guarantees diversity in the future physician workforce. Sheer numbers matter, because major urban and rural areas in the United States remain medically underserved. As a general matter, minority physicians are more likely than their white counterparts to specialize in primary care,[133] and to provide care to patients of color.[134] One study suggests that minority patients are four times more likely than white patients to receive care from minority physicians.[135] Another study found that 22% of physicians provided about eighty percent of primary care to African American patients.[136]

---

[131] *See id.*

[132] *See id.* (noting that the "full-time, salaried, clinical faculty" are instrumental in bringing to their interactions with medical students "different experiences, different training, different values, and different reward systems").

[133] *See* Stephen N. Keith, *Effects of Affirmative Action in Medical Schools: A Study of the Class*, 313 NEW ENG. J. MED. 1519, 1521–22 (1985) (finding that one-third more minority medical school graduates chose primary care specialties than their white classmates, and that approximately forty percent fewer minority graduates became board-certified in a specialty).

[134] For example, one study found that African American physicians practice in areas where the percentage of African American residents was nearly five times higher than in areas where white physicians practice. *See* Joel C. Cantor et al., *Physician Service to the Underserved: Implications for Affirmative Action in Education*, 33 INQUIRY 167, 174–76 (1996); *see also* Miriam Komaromy et al., *The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations*, 334 NEW ENG. J. MED. 1305, 1307–09 (1996) (finding that African American physicians practiced in areas with five times the percentage of African American residents compared with the practice locations of other physicians and that Hispanic physicians similarly tended to locate their practice in areas with twice the percentage of Hispanic residents than other physicians' practices). More recent research confirms this trend. Howard K. Rabinowitz et al., *The Impact of Multiple Predictors on Generalist Physicians' Care of Underserved Populations*, 90 AM. J. PUB. HEALTH 1225, 1226 (2000).

[135] Put another way, over a third of minority patients received care from nonwhite physicians, compared with just eleven percent of white patients. Ernest Moy & Barbara A. Bartman, *Physician Race and Care of Minority and Medically Indigent Patients*, 273 J. AM. MED. ASS'N 1515, 1517 (1995) (finding that minority patients were four times as likely as white patients to seek health care from minority physicians).

[136] *See* Peter B. Bach et al., *Primary Care Physicians Who Treat Blacks and Whites*, 351 NEW ENG. J. MED. 575, 579 (2004) (surveying over 150,000 primary care visits by African American and white Medicare beneficiaries to 4355 primary physicians and finding that "visits by black patients were markedly more likely than visits by white patients to be to black physicians" and that physicians who treated African American patients "provided more charity care, derived a higher percentage of their practice revenue from Medicaid, more often practiced in low-income neighborhoods, and were less likely to have obtained board certification in their primary specialty . . . than physicians treating white patients"). Although the data described in this section primarily supports the argument that patients prefer to receive care from physicians of the same race and that cultural competence improves quality

The Association of American Medical College's Medical School Graduation Questionnaire for 2004 indicated that approximately one-fifth of graduating medical students intended to practice in medically underserved areas.[137] The intent to practice in such areas varied significantly by race; over 50% of African American students, 41% of Native American students, and 33% of Hispanic students intended to locate their practices in underserved areas compared with only 18% of white students.[138] At the same time, recent data suggest that levels of URM physicians continue to drop compared with the diversity of the populations they serve,[139] and without a continued commitment on the part of medical schools to train a diverse population of physicians, the diversity gap between physicians and the patient population will continue to widen.[140]

Some commentators disagree that studies suggesting that minority physicians will provide care for disproportionately high numbers of minority patients can justify affirmative action in medical school admissions. Instead, those who take this position suggest that any medical school applicant who expresses an intention to provide care in underserved areas of the country should receive consideration in the evaluation process for such an altruistic impulse.[141] Admissions committees already consider

---

of care, Bach's data raises a separate and unsettling possibility that lower rates of board certification among African American physicians and differences in quality of clinical training between African American and white physicians may separately contribute to inferior quality of care for African American Patients. *Id.* at 582–83. This supposition, if correct, suggests that medical schools must not only make an effort to train more URM physicians but also ensure that these physicians successfully obtain residencies that position them to provide high quality care for the population where their practices are located and that emphasize the importance of pursuing board certification.

[137] FACTS AND FIGURES 2005, *supra* note 96, at 9.

[138] *Id.* Several theories have been offered to explain this phenomenon. In areas of the country with segregated neighborhoods, non-white physicians may more willingly practice in minority neighborhoods, and white patients may feel reluctant to visit non-white physicians. *See* Moy and Bartman, *supra* note 135, at 1517, 1519 (explaining that physician willingness to provide care to minority patients may also be impacted by the recency of the physician's training and by physician-patient language concordance, but that little data on these variables was available and that race of the physician appeared to be the most significant predictor).

[139] *See* Jeffrey J. Stoddard et al., *The Respective Racial and Ethnic Diversity of US Pediatricians and American Children*, 105 PEDIATRICS 27–28 (2000) (finding that the ratio of African American, Hispanic, and other URM pediatricians is dropping and is far less diverse compared with the racial composition of the U.S. population of children).

[140] *See* Cohen et al., *supra* note 101, at 94 (explaining that "in light of changing U.S. demographics, stagnation or reduction in minority representation within the physician workforce will, in all probability, have unwelcome consequences for the health of the nation"); Richard A. Cooper, *Medical Schools and Their Applicants: An Analysis*, 22 HEALTH AFF. 71, 72 (2003) (concluding that demand for physicians generally will grow more rapidly than supply, that by 2025 the resulting shortfall could be as large as 200,000 physicians and noting that the number of URM applicants to medical schools is currently declining); Joan Y. Reede, *A Recurring Theme: The Need for Minority Physicians*, 22 HEALTH AFF. 91, 92 (2003) (agreeing that the need for URM physicians will continue to grow and recommending the "creative use and expansion of existing financing, regulatory, and community benefit mechanisms to encourage active participation of medical schools" in diversity efforts).

[141] *See, e.g.*, CARL COHEN, NAKED RACIAL PREFERENCE 51 (1995) (arguing that this assumption fails to justify affirmative action in medical school admissions because, "[i]f the intention to give

each applicant's expressed and demonstrated commitment to service in the medical profession, but the data described above suggest that URM physicians more frequently make this sort of career decision and, because of related concerns about cultural competence described below, minority race ought to work as an additional plus in the applicant's favor.[142]

Separately, however, the workforce diversification argument for affirmative action in medical school admissions rests on a troubling assumption that only URM physicians can effectively communicate with and provide high quality care for minority patients. While it may be true that minority patients trust and communicate more effectively with minority physicians, an ideal of racial concordance between physician and patient is both impractical and short-sighted.[143] The long-term goal is to teach and support communication skills and the exercise of clinical judgment that will foster understanding and trust between physician and patient, regardless of the race of either. In this sense, the diversification of the physician workforce represents a step along a path to improved medical care in which the race of patient and physician ultimately becomes irrelevant.

To achieve this goal, diversity in medical education plays a separate and ultimately more important role, that of breaking down racial, cultural, and religious stereotypes by exposing individual students of all backgrounds to the different perspectives and experiences of their classmates.[144] Whatever the physician's race, the ability of physicians to communicate with patients whose racial, ethnic, or religious backgrounds differ from their own remains crucial to improving quality of care for all patients. Those who have examined cultural barriers to medical care

---

service to particular segments of the community is to be a consideration in admission to professional school, let that be known, and let all persons, of whatever race, make their case for establishing such intentions, if they claim them").

[142] Although it would be inappropriate to assume that an URM applicant to medical school will likely practice in an underserved area, much less have any obligation to do so, the data suggest that URM graduates are far more likely to treat African American, Hispanic, and other minority patients. A cynic might also add that expressing an intention in one's medical school application to practice in an underserved area might be used as a pretext to garner points on the applicant's admission score and that anyone can express that intention.

[143] In fact, some commentators dispute the notion that physician-patient racial concordance promotes communication or improved quality of care at all. *See* SATEL, *supra* note 112, at 175–76 (describing studies suggesting that physician-patient racial match was less important than factors such as reputation, convenient location, and good communication style); *see also id.* at 182–83 (commenting that "in this era of managed care's fifteen-minute doctor visit, what much of the research [on the effect of cultural differences on the doctor/patient relationship] tells us is that most patients attach more value to the amount of time they can spend with their doctor than to the doctor's race or ethnicity").

[144] *See* Elizabeth S. Anderson, *Integration, Affirmative Action, and Strict Scrutiny*, 77 N.Y.U. L. REV. 1195, 1196 (2002) (arguing that "[i]ntegration is both a direct remedy for segregation in the practicing institution and an indirect remedy for segregation elsewhere in society"); *see also* THE YALE GUIDE, *supra* note 127, at 202 (explaining that the "richness of a diverse medical school class is stimulating in a number of ways. Most students are repeatedly enriched by the experiences of their classmates whose lives have been different from their own").

describe communication barriers in sharply evocative language. As Anne Fadiman explains in her wonderfully informative book about the cultural conflicts between a community of Hmong immigrants and the staff of a county hospital, such conflicts operate as "collisions, which made it sound as if two different kinds of people had rammed into each other, head on."[145]

Exposure during intensive medical training to the views and perspectives of classmates from varied racial, cultural, economic, and religious backgrounds helps to eradicate stereotypical assumptions and outright bias that may disrupt the physician's ability to make sound medical recommendations or may diminish the patient's trust in the physician.[146] During medical school, students who spend long hours of training with contemporaries of different races and ethnicities develop better communication skills and a finer ability to understand and interact with sensitivity to patients who differ from themselves.[147] In the medical delivery context, commentators refer to such skills as "cultural competence"[148] though the term encompasses much more than simply achieving a passing understanding of, for example, "Black culture" or "Hispanic culture" or "Muslim religion."[149] In fact, although some

---

[145] *See* ANNE FADIMAN, THE SPIRIT CATCHES YOU AND YOU FALL DOWN: A HMONG CHILD, HER AMERICAN DOCTORS, AND THE COLLISION OF TWO CULTURES, at vii–viii (1997) (describing, with exquisite detail and insight, the cultural and language barriers between American physicians and a Hmong family with an epileptic child and that family's loss of trust in the medical system).

[146] *See* Lisa C. Ikemoto, *Racial Disparities in Health Care and Cultural Competency*, 48 ST. LOUIS U. L.J. 75, 100–01 (2003) (arguing that the goals and effects of cultural competency training are to counter "racially and ethnically exclusive health care" by identifying racism as a problem in health care and addressing its effects at both the institutional level and by individual providers and suggesting that such training, by creating self-awareness about individual and institutional values, can improve the quality of health care for minority patients); *see also* Frederick M. Chen et al., *Patients' Beliefs About Racism, Preferences for Physician Race, and Satisfaction With Care*, 3 ANNALS FAMILY MED. 138, 140–42 (2005) (finding that African American and Latino patients who perceived racism in the health care system were more likely to prefer a physician of their own race and that African Americans were more likely to express satisfaction about care received from a racially-concordant physician); Chanita Hughes Halbert et al., *Racial Differences in Trust in Health Care Providers*, 166 ARCHIVES INTERNAL MED. 896, 898 (2006) (concluding that African Americans were significantly more likely to express distrust in their physicians compared with white patients).

[147] As Justice O'Connor explained in *Grutter*, diversity enhances the classroom experience by promoting livelier discussion and helping to break down racial stereotypes. *See* Gruter v. Bollinger, 539 U.S. 306, 330 (2003) (explaining that a diverse student body enhances the legal education and "better prepares students for an increasingly diverse workforce"); *see also* Cohen et al., *supra* note 101, at 92–93 (arguing that "[o]nly by encountering and interacting with individuals from a variety of racial and ethnic backgrounds can students transcend their own viewpoints and see them through the eyes of others. A heterogeneous campus helps students to recognize that their own opinions are influenced by their unique race, gender, origin, and socioeconomic status").

[148] *See* Ikemoto, *supra* note 146, at 97–98 (providing various definitions of cultural competence and discussing the assumptions they share in common).

[149] *See* Joseph R. Betancourt, *Cultural Competence—Marginal or Mainstream Movement?*, 351 NEW ENG. J. MED. 953, 953 (2004) (criticizing efforts to teach "dos and don'ts" for caring for "the Hispanic patient" and arguing that although learning about particular cultures can be helpful, "but when broadly applied, this approach can lead to stereotyping and oversimplification of culture"); *cf.* Selmi, *supra* note 121, at 729–30 (discussing the "contentious" argument about whether African Americans

unifying cultural or religious principles may predominate, the key to true cultural competence lies in the ability to communicate with patients as individuals, while being attentive to the potential impact of cultural issues, and to maximize the quality of medical decision-making through a respectful understanding of each patient's individual beliefs, preferences, concerns, and ability to comprehend.[150]

This concept of individualized communication nevertheless remains in tension with questions about the relevance of patient race to medical care. A patient's race (and sometimes religion or cultural background) is undeniably relevant in certain instances to making an accurate diagnosis or plan of care. For example, certain diseases occur more frequently in African Americans than in Caucasians,[151] and understanding patterns of disease incidence and risk remains essential to the practice of medicine.[152] On the other hand, while remaining aware of these trends, physicians must take care to avoid racial profiling of their patients because of the risk of stereotyping and excess rates of misdiagnosis by race.[153] As research into the role of genetic variation in disease progresses, race ultimately will become a biologically meaningless term. For now, it serves as a cumbersome and not very accurate predictor of far subtler genetic and

---

share a particular viewpoint which contributes to diversity in institutions of higher education and explaining that Bowen and Bok's data instead support the conclusion that a diverse student body benefits all students on campus by increasing the likelihood that student will become community leaders rather than simply justifying diversity by treating "black students as objects for the school's own purposes" or expecting black students "to give the black perspective on affirmative action or to instruct white students on black culture").

[150] *Cf.* Betancourt, *supra* note 149, at 953 (describing the evolution of cultural competence "from the making of assumptions about patients on the basis of their background to the implementation of the principles of patient-centered care, including exploration, empathy, and responsiveness to patients' needs, values, and preferences").

[151] For example, in the United States, African Americans in some age groups have as much as a twenty-fold higher incidence of end-stage renal disease compared with Caucasians. *See* Lawrence Y. Agodoa et al., *Effect of Ramipril vs Amlodipine on Renal Outcomes in Hypertensive Nephrosclerosis: A Randomized Controlled Trial*, 285 J. AM. MED. ASS'N 2719, 2719–20 (2001). Gaucher Disease occurs most frequently in Ashkenazi Jews. *See* Shachar Zuckerman et al., *Carrier Screening for Gaucher Disease: Lessons for Low-Penetrance, Treatable Diseases*, 98 J. AM. MED. ASS'N 1281, 1282 (2007). Certain types of cancer are also markedly more prevalent among African Americans compared with Caucasians. *See supra* notes 39, 40, 43, 51 and accompanying text (providing citations for multiple studies documenting variations in the prevalence of cancer and other disease based on race).

[152] *See* Marshall H. Chin & Catherine A. Humikowski, *When Is Risk Stratification by Race or Ethnicity Justified in Medical Care?*, 77 ACAD. MED. 202, 203 (2002) (discussing Bayesian thinking and the conceptual framework for thinking about ethnicity as a clinical tool); Elizabeth G. Phimister, *Medicine and the Racial Divide*, 348 NEW ENG. J. MED. 1081, 1081–82 (2003) (acknowledging that the consideration of race or common ancestry in medical research and diagnosis remains controversial but recommending that race receive consideration in diagnosis until the point where medicine becomes personalized on the basis of each patients genetic profile).

[153] *See* Ikemoto, *supra* note 146, at 92–93 (providing an example of how racial profiling can interfere with accurate diagnosis); *see also* J. Dennis Mull, *Cross-Cultural Communication in the Physician's Office*, 159 WEST. J. MED. 609, 610–12 (1993) (providing examples of situations in which lack of understanding of a patient's cultural background can interfere with diagnosis, communication, and compliance with treatment recommendations).

physiologic differences that may or may not manifest along racial lines.[154]

Race, for now, plays a role in diagnosis, but apart from that role, race, as well as religion and other cultural factors, can affect the quality communication between physician and patient. Evidence suggests that most patient complaints arise from communication problems with their physicians.[155] Health care scholars have argued that the minority patient population's lack of trust in the predominately white medical system discourages these patients from seeking early medical attention, even when such care is accessible.[156] In addition to affecting patients' perceptions about the care that they receive and their trust in the medical system, the quality of communication significantly impacts patient adherence to prescribed medical regimens, such as medication and diet.[157] Because patient non-compliance with physician recommendations can contribute to

---

[154] *See* Barbara A. Noah, *The Participation of Underrepresented Minorities in Clinical Research*, 29 AM. J. L & MED. 221, 235–36 (2003) (describing the scientific debate about the relevance of race to medicine and providing examples of genetic variations in response to medical treatments that occur along racial lines).

[155] *See* Tessa Richards, *Chasms in Communication: Still Occur too Often*, 301 BRIT. MED. J. 1407, 1407 (1990) (discussing how most patients complain more about a "perceived failure of the doctors concerned to communicate adequately"). In fact, the degree to which physician and patient engage in "participatory decision- making," not the racial or ethnic "match" between physician and patient, appropriately appears to correlate most closely with patient satisfaction. *See* Lisa Cooper-Patrick et al., *Race, Gender, and Partnership in the Patient-Physician Relationship*. 282 J. AM. MED. ASS'N 583, 586–88 (1999) (finding that patients with race-concordant physicians rated their physicians as more participatory than patients whose race differed from their own and concluding that racial differences "are often barriers to partnership and effective communication").

[156] *See* Randall, *supra* note 31, at 191–92 ("[F]ear and distrust of the health care system is a natural and logical response to the history of experimentation and abuse. . . . That perspective keeps African Americans from getting health care treatment."); *see also* Mark P. Doescher et al., *Racial and Ethnic Disparities in Perceptions of Physician Style and Trust*, 9 ARCHIVES FAM. MED. 1156, 1162 (2000) (arguing that minority groups reported less positive perceptions of physicians than whites); Nalini Ranjit et al., *Psychosocial Factors and Inflammation in the Multi-Ethnic Study of Atherosclerosis*, 167 ARCHIVES INTERNAL MED. 174, 174 (2007) (concluding that patients who expressed high levels of "cynical distrust" in their health care providers or in the system had concurrently high levels of inflammatory markers which are associated with cardiovascular disease). Health policy specialists, physicians, and even corporations are beginning to respond to the problems created by this fear and distrust of the health care system. The Wrigley Corporation and Health Watch, a health advocacy group, recently joined together to produce an advertising campaign designed to encourage African Americans and other minorities to visit doctors for preventive care, and to seek early detection and control of disease. *See* Leon E. Wynter, *Wrigley Ads to Focus on Minority Health*, WALL ST. J., June 4, 1997, at B1, *available at* LEXIS, News Library, WSJNL, File (discussing the $10 million commercial campaign aimed at getting minorities to use doctors for regular health maintenance rather than as a last resort).

[157] *See* Judith A. Hall et al., *Meta-Analysis of Correlates of Provider Behavior in Medical Encounters*, 26 MED. CARE 657, 657, 666 (1988) (summarizing the results of forty-one independent studies). Although the study did not focus on race, the research team noted a trend suggesting that white patients receive more detailed information during consultation with providers than do African American patients. *See id.* at 667; *see also* Terry C. Davis et al., *Literacy and Misunderstanding Prescription Drug Labels*, 145 ANNALS INTERNAL MED., 887, 887 (2006) (focusing on health literacy generally and concluding that patients with lower literacy taking multiple prescriptions had greater difficulty comprehending instructions on drug labels); NATIONAL HEALTHCARE DISPARITIES REPORT, *supra* note 27, at 127.

undesirable therapeutic outcomes,[158] it seems fairly obvious that physicians must ensure that their patients genuinely understand how to "follow doctor's orders." The lower education and literacy rates among African Americans and other racial minority groups contribute to the challenges of providing quality medical care, impacting various issues such as medication compliance and informed consent. According to data from the most recent census, the correlation between minority race, poverty, and lower educational attainment remains stubbornly constant,[159] making these problems more frequent among patients of color. Patients with low literacy levels have significant difficulty, for example, with appropriate prescription medication use,[160] necessitating careful communication by prescribing physicians to improve the safety and efficacy of drug therapy for these patients. In addition, educational programs to promote cultural competence must acknowledge and address the problem of language barriers where they exist.[161]

The problem of cultural bias and lack of understanding runs in two directions. Apart from the impact of communication problems on patient trust and compliance with recommended medical care, a physician's

---

[158] *See* John Homberger et al., *Bridging Language and Cultural Barriers Between Physicians and Patients*, 112 PUB. HEALTH REP. 410, 410–11 (1997) (noting that "[w]hen a physician and patient do not share a common language or culture, communication difficulties may compromise the patient's care, potentially resulting in worse health outcomes, especially among patients with complex or chronic medical problems").

[159] *See* U.S. Census Bureau, American Community Survey, Nov. 7, 2006, *available at* http://www.census.gov/population/www/socdemo/education/cps2006.html (click links for Table 1: "All Races" and Table 8a: "Both Sexes") (concluding that, although African Americans now graduate from high school at higher rates than in 1990 or 2000, the college graduation rate has declined; seventeen percent of African American adults had a bachelor's degree or higher in 2005 compared with thirty percent of white adults and twelve percent of Hispanic adults and that the median income for African American households remains at about sixty percent of the average of white households since 1980).

[160] *See* Davis et al., *supra* note 157, at 887 (concluding that, even in English-speaking populations, lower literacy levels and higher numbers of prescription medications independently contributed to errors by patients in following medication instructions).

[161] Language barriers, for example, directly impact a patient's experience with health care providers, though language barriers are only one of a multitude of factors which influence doctor-patient communication. *See* NATIONAL HEALTHCARE DISPARITIES REPORT, *supra* note 27, at 127 fig.4.11 (providing data from a study that concluded that approximately seventeen percent of non-English speaking patients complained that their health care providers failed to listen carefully, explain clearly, or demonstrate respect for the patient compared with ten percent of English speaking patients); *see also* Glenn Flores, *Language Barriers to Health Care in the United States*, 355 NEW ENG. J. MED. 229, 230 (2006) (describing the "deleterious effects" of language barriers on the quality of medical care and on outcomes and explaining that the use of ad hoc interpreters such as family members may lead to more medical error as well as raising confidentiality issues). For now, health care providers rely too often on children, many under the age of twelve, to serve as interpreters when they provide care for non-English speaking patients. Because children lack the medical vocabulary or comprehension of complex health concepts to convey physicians' advice or medical options accurately, the quality of care undoubtedly suffers. *See* Karen C. Lee et al., *Resident Physicians' Use of Professional and Non-Professional Interpreters: A National Survey*, 296 J. AM. MED. ASS'N 1050, 1051–53 (2006) (finding that most residents received little or no instruction about how to assess patient comprehension or literacy and that twenty-two percent of physicians surveyed had used children as informal interpreters).

stereotypical or biased beliefs can interfere with his or her exercise of decision-making authority in making recommendations among different treatment alternatives. Thus, part of the cultural competence curriculum should address awareness of disparities in health care and the influence that race and ethnicity may exert on clinical decision-making.[162] The discretionary nature of medical decision-making opens the door to conscious and unconscious racially-biased assumptions on the part of health care providers.[163] As Professor Gregg Bloche has explained, most medical decisions lack empirical and scientific support, and, because physicians usually have a variety of diagnostic and therapeutic choices, "wide variations in the incidence of many common medical and surgical procedures have been documented within small geographic areas and between individual practitioners."[164] Professor Bloche observes that the relatively unconstrained nature of clinical decision-making paves the way for physicians' stereotypical beliefs to influence their judgment about appropriate treatment options for individual patients.[165] Together with "the attenuation of empathy across racial lines in clinical relationships," physicians' judgment can be distorted, even in the absence of conscious racism.[166] For these reasons, cultural competence curricula should address not only the communication issues described above but should also press physicians in training to identify and confront their own biases and to consider how they may affect their exercise of clinical judgment.

Many medical schools now include a communication skills component in their curriculum, either at the medical college or graduate medical education stage, often as part of a course dealing with the physician-patient

---

[162] *See* Betancourt, *supra* note 149, at 954 (adding that this component also addresses the problem of patient mistrust in the medical profession).

[163] *See* Noah, *Racial Disparities*, *supra* note 32, at 154–56 (suggesting that the evidence of racial disparities in how health care is delivered supports the conclusion that physician's treatment decisions, at least sometimes, reflect unstated prejudices about their patients); Randall, *supra* note 31, at 213 (noting that racist conduct by health care providers can be intentional or unintentional). Professor Randall concludes that the disparate care received by African American patients constitutes a more explicit and avoidable kind of racism: "Eurocentric bioethical principles such as autonomy, beneficence, and informed consent . . . . leave considerable room for individual judgment by health care practitioners. . . . In a racist society (such as ours), the judgment is often exercised in a racist manner." *Id.* at 231 (footnote omitted).

[164] M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL'Y L. & ETHICS 95, 100 (2001).

[165] *See id.* at 104 (explaining that "[p]hysicians' expectations and suspicions concerning therapeutic compliance and the presence of such co-morbid factors as substance abuse, poor living conditions, and lack of family and social support figure prominently in clinical judgments concerning patients' ability to adhere to risky and costly courses of treatment. Suppositions about patients' truthfulness, self-discipline, laziness or industry, . . . tolerance for pain, and intelligence influence both diagnostic impressions and treatment recommendations" and that when these presuppositions are race-based, disparities in clinical discretion can follow) (footnote omitted).

[166] *Id.*; *see also* Crossley, *supra* note 31, at 218–23 (describing evidence of the impact of race on the use of various therapies and observing that the operation of stereotypes in clinical decision-making has been studied far less frequently than the existence of racial disparities).

relationship. Most programs cover the subject of patient communication as part of an existing required course, although others offer it as a stand-alone required course or elective.[167] In some medical schools, the "Introduction to Clinical Medicine" or equivalent course includes topics such as patient interviewing and communication, as well as discussions about the interrelationships between race, gender, poverty and health.[168] The Association of American Medical Colleges' accreditation standards do require that both medical school faculty and students have an understanding of diverse cultures and beliefs that may affect health care and that students become aware of their own cultural biases.[169] It is difficult to determine the content of such courses and they apparently comprise a very small percentage of the curriculum in both the four-year program and in residency programs.

Along the same lines, some commentators have urged medical schools

---

[167] *See* ASS'N AM. MED. COLLEGES, 1996–1997 CURRICULUM DIRECTORY 12 tbl.6 (indicating that 108 medical schools cover the physician-patient relationship as part of a required course, another twenty-three programs offer the course as a required separate course, and twenty-three offer the course as an elective); *see also* Mary Anne C. Johnston, *A Model Program to Address Insensitive Behaviors Toward Medical Students*, 67 ACAD. MED. 236, 236–37 (1992) (describing a program at the University of Pennsylvania School of Medicine designed to educate students and faculty members about insensitive behavior towards minority groups, women, and gays and lesbians, and noting that medical schools wishing to graduate sensitive and caring physicians can begin the process by addressing instances of disrespectful behavior that arise during the medical education program). As of 2000, only one medical school offered a separate required course dealing with cultural competency, though eighty-seven per cent of medical schools included content on cultural competency as part of a required course or clerkship and sixty-seven percent covered cultural beliefs about death and dying. Barzansky et al., *supra* note 127, at 1118.

[168] *See* Elysa Gordon, Note, *Multiculturalism in Medical Decisionmaking: The Notion of Informed Waiver*, 23 FORDHAM URB. L.J. 1321, 1355 & n.193 (1996) (also describing other suggested approaches for improving cross-cultural communication in the healthcare context).

[169] The relevant standards provide as follows:

> ED-21. The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. All instruction should stress the need for students to be concerned with the total medical needs of their patients and the effects that social and cultural circumstances have on their health. To demonstrate compliance with this standard, schools should be able to document objectives relating to the development of skills in cultural competence, indicate where in the curriculum students are exposed to such material, and demonstrate the extent to which the objectives are being achieved.
>
> ED-22. Medical students must learn to recognize and appropriately address gender and cultural biases in themselves and others, and in the process of health care delivery. The objectives for clinical instruction should include student understanding of demographic influences on health care quality and effectiveness, such as racial and ethnic disparities in the diagnosis and treatment of diseases. The objectives should also address the need for self-awareness among students regarding any personal biases in their approach to health care delivery.

LIAISON COMMITTEE ON MEDICAL EDUCATION, FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL: STANDARDS FOR ACCREDITATION OF MEDICAL EDUCATION PROGRAMS LEADING TO THE M.D. DEGREE 15–16 (2007), *available at* http://www.lcme.org/functions2007jun.pdf; *see also* THE HENRY J. KAISER FAMILY FOUNDATION, COMPENDIUM OF CULTURAL COMPETENCE INITIATIVES IN HEALTH CARE 5 (2003) (noting that "[p]ublic and private sector organizations are involved in a number of activities that seek to reduce cultural and communication barriers to health care").

to train students about issues surrounding race and health care, including the development of courses specifically designed to increase sensitivity and improve understanding of diverse ethnic groups.[170] In addition, a relatively recent addition to the medical boards requires prospective physicians to pass a patient interview component. The Clinical Skills component of the United States Medical Licensing Examination is designed to assess whether a medical student demonstrates the fundamental skills necessary for effective diagnosis of and interaction with patients.[171] Finally, as physicians in training learn about the role of cultural issues, they should be prepared to examine their own attitudes and behaviors critically in order to detect their own internal biases and move beyond them to understanding the individual needs of their patients.[172]

The medical education community clearly recognizes the value of cultural competence training but, if medical educators genuinely take such training seriously, they must devote more classroom hours to it. In the same vein, because individual patient's religious beliefs can impact their preferences and their understanding of medical options, medical schools should include, in their efforts at cultural competence training, curricula that assist physicians with understanding and incorporating religious beliefs into patient care.[173] As a corollary to these curricular reforms,

---

[170] *See, e.g.*, Betancourt, *supra* note 149, at 954 (suggesting that interactive, case-based learning sessions are the most effective means of educating future physicians about these issues); Cooper-Patrick et al., *supra* note 155, at 589 (calling for communication training programs for medical students and residents that "include an emphasis on understanding and addressing the needs of a patient population that is becoming more culturally diverse"); Renée C. Fox, *Cultural Competence and the Culture of Medicine*, 353 NEW ENG. J. MED. 1316, 1318 (2005) (arguing that medical schools must teach cultural competence including "the systematic acquisition of in-depth knowledge and understanding of at least one society other than one's own" and that such training is essential to "heightening one's appreciation of commonalities and differences among cultures").

[171] *See* United States Medical Licensing Examination, 2008 Orientation Materials, http://www.usmle.org/Orientation/Step2CSslideshow/slide004.asp (last visited Oct. 29, 2007) (explaining that clinical skills assessed include "taking a relevant medical history, performing an appropriate physical examination, communicating effectively with the patient, clearly and accurately documenting the findings and diagnostic hypotheses from the clinical encounter, and ordering appropriate initial diagnostic studies").

[172] *See* H. Jack Geiger, *Race and Health Care—An American Dilemma?*, 335 NEW ENG. J. MED. 815, 816 (1996) (noting that physicians may not recognize that race may influence their clinical decisions). Dr. Geiger suggests that physicians confront the following questions:

> What choices are black patients and white patients actually offered by their physicians? What do they hear? Do their physicians make specific recommendations? Do the patients participate fully in the decision-making process? What criteria do physicians use in making these clinical judgments? Are they applied equitably, or are they subtly influenced by racial stereotyping on the part of time-pressured physicians, reinforced both by institutional attitudes and by unwarranted assumptions about prevalences and outcomes?

Id.; *see also* Gordon, *supra* note 168, at 1355 (suggesting practice guidelines and incentives that "encourage physicians to approach patients about their cultural values").

[173] *See* Richard P. Sloan et al., *Should Physicians Prescribe Religious Activities?*, 342 NEW ENG. J. MED. 1913, 1913–16 (2000) (noting that approximately thirty United States medical schools offer courses on religion, spirituality, and the connection with health but noting that increasing cultural and

Congress must retain its commitment to encouraging the training of minority health care professionals.[174] Encouraging minorities to enter the health care professions in greater numbers will help to create a culture of trust between the health care system and its minority patients, with the ultimate goal to train all physicians to communicate well with their patients while keeping the gates to careers in medicine open to a diverse population of future physicians.

Moreover, medical educators must recognize that adding cultural competence training without retaining a commitment to diversity in the classroom probably will fail to improve cultural competence. Medical schools need that, admittedly difficult to define, "critical mass" of URM students, as well as students from various religious, socio-economic, and geographic backgrounds, in order to promote open discussion about and familiarity with the impact of racial, religious, familial, and other factors on patients:

> In acquiring the necessary skills to provide appropriate care for their diverse patients, all students, irrespective of their individual backgrounds, must gain a firm grasp on how various belief systems, cultural biases, family structures, historical realities, and a host of other culturally determined factors influence the way individuals experience illness and the way they respond to advice and treatment.[175]

Medical students do not truly understand these concepts from reading textbooks.[176] There is a direct correlation between classroom diversity and these pedagogical goals—a critical mass of students from various backgrounds normalizes frank and open discussion about these issues and makes them more difficult to dismiss. Having only a small number—one

---

religious diversity makes it difficult for physicians to "engage patients in meaningful discussions about religion").

[174] *See* Sullivan, *supra* note 4, at 2674 (noting that the executive and legislative branches have worked together to "provide more funds and incentives for the training of minority health professionals"). One set of programs, created under the Disadvantaged Minority Health Improvement Act of 1990, Pub. L. No. 101-527, 104 Stat. 2311 (codified in scattered sections of 42 U.S.C.), instituted a series of federally-funded grants and loan programs aimed at increasing the numbers of minority students enrolled in health professions schools. The Act provides grants to "centers of excellence" at medical and dental schools with the goals of establishing programs to enhance the academic performance of minority students, increasing the numbers of minority students in the programs, improving program recruiting and retention of minority faculty, and facilitating research on health issues affecting minority groups. *See* 42 U.S.C. § 293(a)–(b) (2000). The Act also established grants for scholarships and loan repayment programs to support minority health professions students. *Id.* § 293a–b; *see also* OFFICE OF MINORITY HEALTH, U.S. DEP'T OF HEALTH AND HUMAN SERVS, NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE xviii (2001), *available at* http://www.omhrc.gov/assets/pdf/checked/executive.pdf (recommending support of national, state, and local efforts to expand the pool of health care professionals from minority groups).

[175] Cohen, *supra* note 89, at 1144.

[176] *Id.*

or two or three—of students of color in a class may place undue pressure on those few students to serve as the "voice" of their racial or ethnic group.[177] Even when a student is willing to speak about his or her understanding of a particular racial or cultural issue, instructors should take care to emphasize that individual members of the group in question may not share that particular perspective. By contrast, a "critical mass" of racial minorities makes classroom discussion of issues in which race or ethnicity plays a role more difficult for white students to dismiss.

For all of these reasons, many physicians and commentators have made a strong case for continuing the practice of affirmative action in medical school admissions.[178] As Justice O'Connor explained in *Grutter*, classroom diversity "better prepares students for an increasingly diverse workforce and society and better prepares them as professionals," and "skills needed in today's increasingly global marketplace can only be developed through exposure to widely diverse people, cultures, ideas, and viewpoints."[179] The application of such reasoning to health care delivery seems obvious. Even so, critics have observed that "the whole argument over what whites will learn from the presence of a critical mass suggests that 'diversity' is for the educational benefit of whites," which some students of color may find offensive.[180] In the context of medical education, it is hoped that the interplay between cultural understanding, communication, and quality of care described throughout this Article transcends this superficial critique of the value and effect of diversity.

V. FINAL THOUGHTS AND FUTURE CHALLENGES

Affirmative action remains a controversial and inconsistently effective solution to a complex problem in higher education. Professor Charles Lawrence, for example, has argued that diversity as a justification for

---

[177] *Cf.* Bergen, *supra* note 96, at 1139 (noting that "[o]nce admitted, URM students may feel isolated").

[178] *E.g.*, Cohen, *supra* note 89, at 1143–49.

[179] Grutter v. Bollinger, 539 U.S. 306, 330 (2003) (internal citation omitted).

[180] *See* Thernstrom & Thernstrom, *supra* note 90, at 262–63 (describing other critiques of the diversity rationale, and noting especially that the definition of diversity is quite narrow and focuses on increasing the representation of certain underrepresented minority groups, but not on the representation of different religious or ideological viewpoints). Diversity as a rationale in support of affirmative action remains controversial, in part because of the complexity of its benefits and the thorny questions about precisely whose presence in a diverse classroom is benefitting whom. Affirmative action benefits URM students who might otherwise not have an opportunity to attend a particular college or university. At the same time, the presence of URM students in a university benefits white students in the ways explained by Justice O'Connor and others. Depending on one's predisposition to support, or not, affirmative action, this multiplicity of benefit can be positive, fair, and just, or manipulative, derogatory, and self-serving. As one commentator acidly observed: "That [diversity] exception [to the Equal Protection clause] allows white majorities to feel noble while treating blacks and certain other minorities as seasoning—a sort of human oregano—to be sprinkled across a student body to make the majority's educational experience more flavorful." Will, *supra* note 12. This Article does not pretend to resolve this larger conflict of perspective.

affirmative action fails to remedy deeper societal discrimination and, instead, preserves the current flawed university admissions process.[181] By relying on the diversity rationale as a justification for affirmative action, Lawrence argues that defenders of diversity such as Bowen and Bok "defend the integration of an existing elite without questioning that elite's participation in the reproduction of institutional racism."[182] The debate about the merits of the diversity rationale coupled with the rapidly developing literature on "race-neutral" preferences receives fuller treatment elsewhere,[183] but medical schools should take whatever steps necessary and consistent with current law to achieve diversity of race, religion, and socioeconomic background in their student bodies.

This Article does not attempt to summarize and discuss the entire debate about affirmative action in higher education. Instead, it considers the practice of race conscious admissions practices as permitted after the *Grutter* decision and examines the special merits of the practice in medical school education. The *Grutter* decision affirming racial diversity in the classroom as a compelling governmental interest represents an important first step in the process of eliminating bias in health care delivery. The commitment to diversity can and should remain steadfast in all higher educational contexts, but the conversation about the value and purpose of affirmative action will prove more productive if it is context-specific. Although a diverse class undoubtedly enhances the learning experience for students in undergraduate programs, law, and business schools, the stakes are simply different in medical education. The trickle down effect of under-representation of racial minorities in health care delivery has a far greater impact on society than similar under-representation in law services or business enterprises. It would be indefensible to return to essentially de facto segregated medical education in this era of rapid minority population growth in the United States and continued health disparities between whites and racial minorities. Medical schools must remain committed to social justice as a key component of the ethic of professionalism that students develop during their training.

The United States government has acknowledged the vexing and

---

[181] *See* Lawrence, *supra* note 6, at 940 (explaining that the liberal defense of affirmative action using the diversity rationale "leaves no room for deeper criticisms of the racial hierarchy—a hierarchy that produces unequal secondary education as well as past and ongoing racism, both deliberate and unconscious, at institutions of higher learning").

[182] *Id.*

[183] *See, e.g.*, Charles R. Calleros, *Law, Policy, and Strategies for Affirmative Action Admissions in Higher Education*, 43 CAL. W. L. REV. 151, 166–69 (2006) (describing race-neutral admissions approaches such as lotteries or "percentage of the top graduates" rules and using criteria that give weight to non-race based attributes such as economic disadvantage); Kim Forde-Mazrui, *The Constitutional Implications of Race-Neutral Affirmative Action*, 88 GEO. L.J. 2331 (1999) (considering broadly the constitutional implications of race-based versus race-neutral affirmative action); Peter H. Schuck, *Reflections on Grutter*, JURIST, Sept. 5. 2003, http://jurist.law.pitt.edu/forum/Symposium-aa/Schuck.php (critiquing the *Grutter* majority's constitutional test for upholding preferences).

seemingly intractable problem of health disparities between the races. Although inadequate access to care contributes to much of these health disparities, the dearth of minority physicians in general and the larger problem of inadequate training to improve the ability of physicians to communicate with patients of different racial or ethnic backgrounds makes progress difficult to achieve. Minority physicians remain more likely than white physicians to treat minority patients, and minority patients continue to express a preference for physicians of the same or similar racial background. Ideally, the medical education system will train all physicians to provide high quality care, with respect and compassion, to all patients, regardless of the race of the physician or patient. Proponents of integrated medical education clearly have made significant strides in the last quarter century, but the continued evidence of racial disparities in health care delivery, racial bias and communication problems between physicians and patients demands an ongoing commitment to the inclusion of substantial numbers of underrepresented minority students in medical school.

Many challenges remain. Continued efforts at diversification of medical school classes and cultural competence training represent only the first step in transforming the health care delivery system in ways that will improve the overall health of Americans and particularly of racial and ethnic minorities. Although it is clear that communication issues and unconscious bias negatively affect the quality of care that minority patients receive in a variety of circumstances, recent evidence suggests that interpersonal discrimination is only one piece of a larger puzzle. The lasting effects of societal discrimination and residual segregation also appear to impact the quality of care that minority patients receive.[184] Moreover, although the evidence suggests that training more URM physicians will actually improve quality of care for URM patients, and that non-minority physicians will benefit from education in a racially diverse setting, it will be difficult to measure directly the actual impact of such reforms on quality of care.[185]

---

[184] *See* Epstein, *supra* note 91, at 603 (commenting on study data that suggest that some of the differences in care received by white versus African American patients "seem to reflect the place in which patients seek care, rather than the specific doctor they choose within that place" and noting that the data suggests that geographical segregation also can restrict health care options for minority patients); *see also generally* Bach et al., *supra* note 136 (concluding that "physicians treating black patients may be less well trained clinically and may have less access to important clinical resources than physicians treating white patients"); Outterson, *supra* note 53, at 747–77 (providing a detailed history and insightful comments about the historic role of societal discrimination on the health of African Americans).

[185] *Cf.* Ronald M. Epstein, *Assessment in Medical Education*, 356 NEW ENG J. MED. 387, 393 (2007) (describing the different methods of assessing medical student and physician performance and noting that several domains of assessment, including teamwork, communication, and other abstract aspects of professionalism, are particularly difficult to measure or assess); Daniel Klass, *Assessing Doctors at Work—Progress and Challenges*, 356 NEW ENG. J. MED. 414, 415 (2007) (recommending more emphasis on "peer-based assessments that target actual performance profiles and meaningful

Ultimately, high quality medical care happens in an environment that encourages meaningful one-on-one interactions between individual health care providers and individual patients. This goal—truly meaningful communication, genuine respect, trust and mutual understanding between patient and physician—if achieved, ultimately can transcend matters of race and culture. An important step toward this goal begins with medical education that trains physicians not only in the science and art of medicine but also in the more universal and essential art of communication. In a society that continues to struggle with matters of race, and in a health care system that continues to deliver health care that is infected with bias, racial diversity in medical education remains an essential tool to train all new physicians to bridge the divide with patients who are different than themselves. Overall, progress is evident and it is heartening. In the past couple of decades, health quality research has moved from recognizing the deeply troubling evidence of racial disparities, to acknowledging that such disparities present challenging ethical and legal dilemmas, to attempting to understand the causes of these disparities and, ultimately, to devising strategies to address them. This final step will undoubtedly prove most challenging.[186] At the very least, graduating classes of new physicians who are aware of and attentive to these issues represents an essential step along the path to equality in health care.

practice outcomes" and more attention to the multiple working relationships that physicians have, not only with patients, but also with colleagues).

[186] *See* Epstein, *supra* note 91, at 605 (observing that "describing and explaining racial disparities in the use of health care services have proved much easier to accomplish than devising strategies to reduce the disparities").