Nos. 20-1199 & 21-707

IN THE

Supreme Court of the United States

STUDENTS FOR FAIR ADMISSIONS, INC.,
Petitioner,
v.
PRESIDENT AND FELLOWS OF HARVARD COLLEGE,
Respondent.

STUDENTS FOR FAIR ADMISSIONS, INC.,
Petitioner,
v.
UNIVERSITY OF NORTH CAROLINA, ET AL.,
Respondents.

On Writs of Certiorari
to the United States Courts of Appeals
for the First and Fourth Circuits

BRIEF FOR AMICI CURIAE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ET AL. IN SUPPORT OF RESPONDENTS

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whose members include all 156 accredited U.S. medical schools; more than 400 teaching hospitals and health systems; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and their more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

AAMC is joined in this brief by a diverse array of 45 other healthcare organizations interested in the issues presented, including:

Fourteen organizations whose members include schools, residency programs, and other institutions involved in educating and training healthcare providers and administrators: the Accreditation Council for Pharmacy Education; American Association of Colleges of Nursing; American Association of Colleges of Pharmacy; American Association of Colleges of Podiatr Coator78 -1.535.002rt Tc * Tw [(Tc TDues Education; American ed..64(n Coata(n of SPodiat)-1(Tw [ssociaf)-1a)6 New Yssociark; 7

Twenty-six organizations whose members include physicians and other healthcare providers: the American Medical Association; American Academy of Child and Adolescent Psyc hiatry; American Academy of Family Physicians; American Academy of Pediatrics; American Academ y of Psychiatry and the Law; American Association for Geriatric Psychiatry; American Association of Directors of Psychiatric Residency Training; American College of Obstetricians and Gynecologists; American College of Physicians; American Colle ge of Psychiatrists; American Pediatric Societ y; American Psychiatric Association; American Pub lic Health Association; American Society of Hemato logy; American Society of Hispanic Psychiatry; Association of American Colleges of Osteopathic Medicine; Association of American Indian Physicians; Association of Women Psychiatrists; Black Psychi atrists of America, Inc.; Council of Medical Specialty Societies; National Asian American Pacific Islander Mental Health Association; National Council of Asian Pacific Islander Physicians; National Hispanic Medical Association; National Medical Association; Philippine Psychiatrists in America; and Society for Pediatric Research; and

Five organizations representing the interests of medical-school students: the American Medical Student Association; Asian Pacific American Medical Student Association; Latino Medical Student Association; National Medical Fellowships, Inc.; and Student National Medical Association.

SUMMARY OF THE ARGUMENT

Diversity in the education of the Nation's physicians and other healthcare professionals is a medical imperative. As an overwhelming body of scientific research compiled over decades confirms, diversity

literally saves lives by ensuring that the Nation's increasingly diverse population will be served by healthcare professionals competent to meet its needs. Research confirms that being treated by a racially diverse care team, or by doctors with exposure to diverse professional or educational environments, greatly increases the likelihood of positive medical outcomes, particularly for minority patients.

For example, in controlled studies, Black physicians are far more likely than others to accurately assess Black patients' pain tolerance and prescribe the correct amount of pain medication as a result. [2] And for high-risk Black newborns, having a Black physician is tantamount to a miracle drug: it more than doubles the likelihood that the baby will live. [3] Yet due to the enduring and significant underrepresentation of minorities in the health professions, many minority patients will not receive care from a racially diverse team or from providers who were trained in a diverse environment.

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[2] SeeKelly M. Hoffman et al.,

These facts present a clear imperative for medical education. It is, of course, neither proper nor possible for all minority patients to be treated by minority healthcare professionals. But medical educators have learned—through both scientific research and years of experience—that health disparities can be minimized when professionals have learned and worked next to colleagues of different racial and ethnic backgrounds in environments that reflect the ever-increasing diversity of the society the profession serves. Thus, diversity in medical education yields better health outcomes not just because minority professionals are often more willing to serve (and often very effective at serving) minority communities, but because ***all*** physicians become better practitioners overall as a result of a diverse working and learning environment.

As the gatekeepers to the medical profession, health-professional schools owe obligations to society at large—not just to their students and applicants. Among those obligations is a responsibility to improve medical care and access thereto for all Americans. The need for such improvements is felt most acutely by minority communities, which generally receive less and lower-quality care than the national average. And given the demonstrated, measurable health benefits of a diverse and diversity-educated medical profession, the Nation's health-professional schools would be shirking those basic obligations if they failed to admit and graduate diverse physicians and other healthcare professionals, and to provide the benefits of a diverse education to all their students.

In Regents of the University of California v. Bakke, 438 U.S. 265 (1978)—a decision that specifically addressed medical education—the Court approved of these principles, with Justice Powell providing the

deciding rationale. As he explained, "[p]hysicians serve a heterogeneous population," and "[a]n otherwise qualified medical student with a particular background—whether it be ethnic, geographic, culturally advantaged," or otherwise, "may bring to a professional school of medi cine experiences, outlooks, and ideas that enrich the training of its student body and better equip its graduates to render with understanding their vital service to humanity." Id. at 314. Twenty-five years later, the Court endorsed Justice Powell's rationale, after observing that "[p]ublic and private universities across the Nation have modeled their own admissions programs on Justice Powell's views." Grutter v. Bollinger , 539 U.S. 306, 323 (2003); see also id. at 387 (Kennedy, J., dissenting). And in the Fisher cases, the Court reaffirmed Bakke yet again. See Fisher v. Univ. of Tex., 570 U.S. 297, 303 (2013) ("Fisher I "); Fisher v. Univ. of Tex. , 579 U.S. 365, 387 (2016) ("Fisher II ").

Justice Powell's words continue to ring true today. In fact, given the Nation's increased—and increasing—diversity, the need to train the next generation of physicians in a diverse educational

In the decades since Bakke, and through Fisher II, the Nation's medical schools have been implementing and refining holistic admissions methods of the type this Court has repeatedly approved. In evaluating an applicant's ability to contribute to and benefit from an enriching educational environment, race is considered merely as one of many factors, none of which is dispositive standing alone. Although test scores and grades are a significant barometer of academic achievement, they have never been independently determinative inw [(and refitaand rls dmission)6 noich

ARGUMENT

I. DIVERSITY IS VITAL TO HEALTHCARE OUTCOMES AND, THEREFORE, TO THE EDUCATIONAL MISSION OF THE NATION'S MEDICAL SCHOOLS.

A. Race-Linked Health Inequities Require Urgent Intervention.

Despite attracting the best medical professionals from around the world, the United States continues to rank shockingly high on certain negative health outcomes compared to other nations. This is likely due in part to the fact that large segments of American society continue to suffer disproportionately from preventable disease and early death notwithstanding the possibility of advanced care. These significant health disparities exist along many axes, including race and ethnicity. [4] Black and Hispanic children with heart conditions are more likely to die than their white counterparts, [5] Black men are twice as likely to die of prostate cancer than white men, [6] and a Black mother is up to four times more likely than a white one to die from childbirth-related complications—with significant disparities existing even controlling for socioeconomic status, lifestyle, insurance coverage,

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[4] See, e.g., Bruce G. Link, Epidemiological Sociology and the Social Shaping of Population Health, 49 J. Health & Soc. Behav. 367, 372-75 (2008).

[5] See, e.g., Jillian Olsen et al., Racial Disparities in Hospital Mortality Among Pediatric Cardiomyopathy and Myocarditis Patients. 42 Pediatr. Cardiology 59, 68 (2021).

[6] See, e.g., Paul Riviere et al., Survival of African American and Non-Hispanic White Men With Prostate Cancer in an Equal-Access Health Care System, 126 Cancer 1683, 1683, 1686 (2020).

and other factors. [7] Thousands of other studies have

seeking medical treatment. [15] It is thus little surprise that while there is no race-linked difference in awareness of healthy lifestyle choices, [16] Black Americans use primary care offices at two-thirds the rate of whites, instead relying more heavily on emergency care.[17]

B. Diversity In Medical Education Markedly Improves Health Outcomes.

The data set forth above is severely troubling. Fortunately, however, studies also confirm that diversity in medical education and practice can help alleviate many of the disparities mentioned. Black and Hispanic medical school graduates are on average likelier than others to consider serving underserved communities. By graduation, 56% of Black and 42% of Hispanic students express interest in practicing with the underserved. [18] A 2015 Senate Report likewise found that "[d]iversity among medical school students is associated with * * * greater willingness to

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[15] Pew Research Center, Race in America 2019 (https://tinyurl.com/ypnametz); see also Christopher Mathis, African Americans and Their Distrust of the Health Care System: Healthcare for Diverse Populations, 14 J. Cultural Diversity 56

serve diverse populations," and that "minority health professionals are more likely to serve in areas with high rates of uninsured and areas of underrepresented racial and ethnic groups." [19] And a 2021 study confirmed that minority health professionals have demonstrably higher rates of following through on stated commitments to practice in underserved communities. [20] Underserved communities are thus particularly dependent on racially and ethnically diverse care teams. [21]

Moreover, there is evidence that a racially diverse care team can produce measurably positive health outcomes for minority patients, [22] both as a result of increased comfort or trust [23] and due to insights into care arising from personal knowledge or experience. [24]

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[19] S. Rep. No. 114-74, at 42 (2015).

[20] See Patricia Pittman et al., Health Workforce for Health Equity , 59 Medical Care S405, S405 -S408 (2021); I.M. Xierali & M.A. Nivet, The Racial and Ethnic Composition and Distribution of Primary Care Physicians , 29 J. Health Care Poor & Underserved 556, 556-57 (2018).

[21] See generally Somnath Saha & Scott A. Shipman, Race-Neutral Versus Race-Conscious Workforce Policy To Improve

And teams of racially diverse physicians and researchers are more likely to focus on identifying medical interventions needed for racial and ethnic minorities. [25]

To be clear: while increasing the racial and ethnic diversity of the medical professions will improve health outcomes, it is of course neither socially desirable nor realistic for minority patients to be treated exclusively by physicians of their own race or ethnicity. The goal of the health professions is not racially segregated care, but rather a workforce in which racial and ethnic representation is a more common aspect of care teams, professionals of all races and ethnicities are able to establish trustful therapeutic relationships with all patients, and the corresponding improvements in health outcomes are experienced as widely as possible. As shown below, in pursuit of that outcome, racially and ethnically diverse peer learning and support is urgently needed to educate the entire medical profession.

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appropriately to help eliminate socio-cultural barriers to care[26] and the humility and understanding to avoid stereotypes about patients from those cultures. [27] Training alongside people with diverse backgrounds can challenge faulty heuristics, improving the crucial care component of effective patient-physician communication. [28]

Based on scientific evid ence, medical schools are committed to fostering a diverse educational environment because a diverse student body produces measurable public health be nefits. For example, as noted, studies showed that white physicians were more likely to assume Black patients had a higher tolerance for pain, and resultingly prescribed them less pain medication. [29] In response to the risks associated with these and other misconceptions, cultural competence has been made a core requirement for entering medical students. [30] And to maintain accreditation medical school curriculums must include cultural competency training, including "the knowledge, skills, and core professional

[26] See

attributes needed to provide effective care in a multidimensional and diverse society." [31]

But this competency cannot simply be imposed from the top down. Such instruction, by itself, can have the unintended outcome of a false sense of expertise, inoculation from error, or deepened attachment to prior beliefs, resulting in a paradoxical increase in errors. [32] But a vast amount of research confirms that members of diverse healthcare teams are less likely to make the types of mistakes they might make in a more culturally homogenous environment. [33] Simply working in a diverse team also increases the expectation and acceptance of respectful inquiry and challenged assumptions. [34] Medical schools therefore pair classroom instruction with peer-to-peer learning [35] for its demonstrated ability to improve

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receptivity to others' insights. [36] And education with diverse peers has been shown to facilitate more meaningful cross-cultural learning. [37]

Medical students who are educated in a diverse student body are thus better able to work with patients of diverse backgrounds. [38] In the healthcare arena, "[r]esearch shows that diverse teams working together and capitalizing on innovative ideas and distinct perspectives outpe rform homogenous teams. Scientists and trainees from diverse backgrounds and life experiences bring different perspectives, creativity, and individual enterprise to address complex scientific problems." [39]

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[36] Teresa Loda et al., Cognitive and Social Congruence in Peer-

racial and ethnic makeup of the Nation. As this Court recognized in Grutter , “student body diversity

experiences, and disparate racial, ethnic, and economic backgrounds, among others. A richly diverse class can contribute to a dynamic, multidimensional educational environment where classroom and study-group discussions add insight to course materials. As Justice Powell put it, "[i]t is not too much to say that the 'nation's future depends upon leaders trained through wide exposure' to the ideas and mores of students as diverse as this Nation of many peoples." Bakke, 438 U.S. at 313 (Powell, J.) (citation omitted).

For the healthcare professions, racial and ethnic diversity is thus not merely an abstract goal, but a medical imperative. Amici have concluded that a diverse educational environment is essential to training physicians who can best address the healthcare needs of this Nation's diverse people. The bodies responsible for accrediting medical schools likewise recognize the important role that student diversity plays in the effective delivery of healthcare. [44] There can be no more compelling interest than that. And as the Court has repeatedly reaffirmed, this educational and medical judgment warrants deference. [45]

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[44] See, e.g., LCME, supra note 31, at 4 (Standard 3.3 noting that a medical should maintain "effective policies" for "achiev[ing] mission-appropriate diversity outcomes").

[45] See, e.g., Fisher II, 579 U.S. at 388 ("Considerable deference is owed to a university in defining those intangible characteristics, like student body diversity, that are central to its identity and educational mission."); Fisher I, 570 U.S. at 311 ("Grutter calls for deference to the University's conclusion, 'based on its experience and expertise,' that a diverse student body would serve its educational goals.") (citation omitted); Grutter, 539 U.S. at 328 ("The Law School's educational judgment that such diversity is essential to its educational mission is one to which we defer."); cf. Sch. Bd. of Nassau Cnty. v. Arline, 480 U.S. 273,

II. MEDICAL SCHOOLS HAVE LONG RELIED ON HOLISTIC REVIEW FOR ADMISSIONS DECISIONS.

A strong grasp of biological sciences and demonstrated academic strengths are prerequisite to the study of medicine. However, consideration of grades and test scores alone is insufficient to select a student body that will achieve a sch

interdependent learners, and furthering each school's educational mission. [48]

A.

For some schools, the range of factors considered during holistic review may include race and ethnicity. However, these factors are considered only as necessary to achieve articulated, mission-driven benefits. To the extent race is considered, this Court has already held that it should not be considered in isolation, and there is no reason to doubt that medical educators adhere to that directive. Race is considered flexibly as just one of the many characteristics and pertinent elements of each individual's background. Characteristics that make an individual particularly well-suited for the medical profession, such as resilience or the ability to overcome challenges, may in many cases be intertwined with a person's race or ethnicity. Further, an applicant's background is a strong predictor of the population or environment in which they will ultimately practice. [55] For example, minority dental-school applicants are more likely than their peers to rate "the desire to work in my own cultural community" as important influences on their choice of practice. [56] And as noted above, minority health professionals have been historically and consistently more likely to follow through with stated commitments to serve underserved communities. [57]

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[55] See Howard K. Rabinowitz et al., The Relationship Between Entering Medical Students' Backgrounds and Career Plans and Their Rural Practice Outcomes Three Decades Later, 87 Acad. Med. 493, 493-95 (2012); Ian T. MacQueen et al., Recruiting Rural Healthcare Providers Today: a Systematic Review of Training Program Success and Determinants of Geographic Choices, 33 J. Gen. Internal Med. 191, 195 (2017).

[56] Elizabeth A. Mertz et al., Underrepresented Minority Dentists: Quantifying Their Numbers And Characterizing The Communities They Serve, 35 Health Affs. 2190, 2195 (2016).

[57] See Pittman et al., supra note 20.

Accordingly, when candidates have overcome challenges, experienced marginalization, or indicated a commitment to serving a particular place or community, obscuring or denying consideration of those applicants' backgrounds will hinder a full appreciation of their potential contributions.

B. It Remains Necessary For Medical Schools To Consider Applicants' Full Backgrounds In Order To Achieve Educational And Professional Aims.

Consistent with the requirements of narrow tailoring, direct consideration of race may continue only as necessary to achieve core aspects of institutions' educational missions. As evidenced by the degree of enduring under-representation in medicine for certain minority groups notwithstanding intensive efforts by medical schools to diversify their classes through race-neutral means, consideration of an applicant's racial or ethnic background is still necessary if a school seeks diversity on those grounds.

Unlike other historically excluded groups, such as women, [58] racial minorities did not organically approach representative parity in the health professions once the most obvious barriers to entry were removed. To the contrary, minorities continue to be significantly underrepresented in the health professions. [59] For instance, in 2019, only 7.3% of

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[58] See Devin B. Morris et al., Diversity of the National Medical Student Body—Four Decades of Inequities , 384 New Eng. J. Med. 1661, 1662-63 (2021) (showing th at medical school enrollment achieved representative gender equity around 2005).

[59] See Edward Salsberg et al., Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce , JAMA Network Open (2021); see also

advanced practice register ed nurses, 5.2% of physicians, and 4.4% of dentists identified as Black, even though Blacks make up 12.1% of the working-age population. [60] Hispanic people (18.2% of the working-age population) represent only 5.5% of advanced practice registered nurses, 6.9% of physicians, and 5.7% of dentists. See id. When examined by medical specialty, underrepresentation has intensified over time, with Black, Hispanic, and Native Americans showing statistically significant downward trends across nearly all ranks and specialties. [61] To take one example, Black men constitute an even smaller percentage of medical students than they did in 1978, when Bakke was decided.[62]

Medical schools continue to implement a host of race-neutral initiatives outside the admissions

middle school,[65] high school,[66] and college students;[67] summer enrichment programs[68] and other "pathway" programs that seek to encourage and prepare minority students to pursue health-professional education;[69] and postbaccalaureate programs.[70] But while these programs have shown some success,[71] their overall impact cannot fully overcome the many

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[65] See, e.g., Morehouse School of Medicine's Ben Carson Science Academy Website (https://tinyurl.com/476hc5wj) (former preparatory program for students in elementary and middle school).

external demographic forces that are beyond schools' ability to control. [72]

Although minority medical school applicants are critically needed to create the kind of diverse classrooms that will help foster cultural competency, their numbers, as noted above, remain very low. Even once exclusion at the higher-education level ceased, societal forces continue to prevent a disproportionate percentage of minority students from building upon a steady foundation for a career in medicine. [73] Most medical school applicants' preparation begins at a young age, with successful applicants having been aided by a combination of early and ongoing resources, quality primary and college education, opportunities, mentoring, role models, financial stability, and

top two household-income quintiles. [75] And only 5% of medical school matriculants come from households in the lowest 20%. See id. Groups underrepresented in medicine disproportionately live in communities with lower household incomes and historically fewer opportunities for wealth accumulation, reducing the likelihood that members of those groups will have the resources to prepare for medical school. And counterintuitively, focusing in admissions on statistical information that correlates with race—such as socio-economic status—would likely reduce rather than increase the number of minority applicants accepted for admission, because low-income minority students are less likely than their non-minority peers to have had access to other resources and support in their early and collegiate years. [76]

Further, medical and other advanced education runs in families. Appr oximately 73% of medical school matriculants have a parent with an advanced degree,[77] and children and grandchildren of physicians are more likely to become physicians than

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[75] SeeJay Youngclaus et al., An Updated Look at the Economic Diversity of U.S. Medical Students , 18 Analysis in Brief No. 5, at 2 (AAMC Oct. 2018).

[76] See Ann Steinecke et al., Race-Neutral Admission Approaches: Challenges and Oppor tunities for Medical Schools , 82 Acad. Med. 117, 123 (2007); Wi lliam G. Bowen & Derek Bok, The Shape of the River: Long-Term Consequences of Considering Race in College and University Admissions 270-71 (Twentieth Anniversary ed. 1998).

[77] See Youngclaus et al., supra note 75, at Table 1 (data aggregated).

children of other professions. [78] The generational experiential inheritance of familial mentorship, beneficial connections, and immersive skill development increases the likelihood of pursuing the medical profession. [79] But the numbers and overall percentages of minority physicians have historically been small. Most medical schools did not admit students from ethnic and racial minority groups until the 1960's and all but two medical schools opened specifically for Black physicians were closed by 1923, serving as a longstanding barrier to the accumulation of professional experiential wealth in these communities. [80]

For these and other reasons, the legacy of American racial injustice has endured longer across the healthcare and medical-education systems than many might have predicted. As a result, notwithstanding significant investment and effort by health-professional programs, if a program seeks a racially diverse student body with more than token representation, most schools will necessarily continue to rely on the consideration of an applicant's racial or

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ethnic background in some cases. And any prohibition on the consideration of race in student admissions will therefore result in a student body with significantly fewer minority students.

III. PRECLUDING OR LIMITING HOLISTIC REVIEW WOULD RESULT IN A COMPOUNDING LOSS OF DIVERSITY AND THREATEN PATIENTS' HEALTH.

For nearly 45 years, the Nation's medical schools have utilized the kinds of holistic admissions processes this Court approved in *Bakke*, *Grutter*, and *Fisher II*. In the schools' expert judgments, such practices are necessary to train physicians and other leaders in the health professions who can effectively serve an increasingly diverse society. Amici urge the Court not to disrupt that reliance by withdrawing its imprimatur from those longstanding practices.

The records of these cases confirm that no justification for parting from stare decisis exists here. For instance, far from being "unworkable," *Payne v. Tennessee*, 501 U.S. 808, 827 (1991), the processes approved in *Grutter*, *Bakke*, and *Fisher II* continue to be the predominant modes of decision making employed by health-professional schools across the Nation. By contrast, it would be difficult, if not impossible, to insulate all consideration of an applicant's race or ethnicity from consideration of the rest of that individual's background. Where an admissions process includes reliance on personal statements, for example, ignoring race and ethnicity "might not even be possible," since "to read the file in a 'colorblind' way, the admissions officer would likely have to ignore highly relevant information, without which the applicant's personal statement might literally not make

sense."[81] And because minorities report at vastly higher rates than white Americans that their race is important to their self-perception and identity, [82] requiring application materials to be truly race-blind

to minority applicants. Harvard Pet. App. 78-79. Diversity fosters more diversity, while homogeneity fosters more homogeneity. Any consideration of whether to risk reducing diversity in higher education must account for the risk of such a spiral, where institutions become not only less diverse, but also unable to attract minority applicants by virtue of their lack of diversity. Banning race-conscious admissions thus will imperil the health and lives of Americans. Amici urge the Court to refrain from taking such a potentially dangerous action.

CONCLUSION

For the foregoing reasons, and those in respondents' briefs, the judgments should be affirmed.

Respectfully submitted,

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