No. 02-241

IN THE

SUPREME COURT OF THE UNITED STATES

BARBARA GRUTTER,

Petitioner,

v.

LEE BOLLINGER, JEFFREY LEHMAN, DENNIS SHIELDS, and the BOARD OF REGENTS OF THE UNIVERSITY OF MICHIGAN,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

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BRIEF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ET AL., AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

This brief addresses only the first of the two questions for which the Court granted the Petition for Writ of Certiorari; namely, whether the University of Michigan Law School's use of racial preferences in student admissions violates the Equal Protection Clause of the Fourteenth Amendment, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d), or 42 U.S.C. § 1981.

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INTEREST OF THE *AMICI CURIAE* [1]

In this case, the Court is asked to determine whether the University of Michigan's law school may consider race and ethnicity as one factor in its admissions policy in order to promote diversity in its student population. While this specific question is narrow, the Court's decision will affect the admissions policies of all professional schools, including medical schools. As a result, the Court's decision will have a substantial effect on the delivery of health care in the United States. The importance of the Court's decision in this regard cannot be overstated.

The Association of American Medical Colleges ("AAMC") is a non-profit corporation whose members include all 126 accredited United States medical schools, approximately 400 teaching hospitals and health systems, and 92 academic and professional societies with an aggregate membership of approximately 100,000 individuals. Founded in 1876, AAMC's primary mission is to improve the health of the public by enhancing the effectiveness of academic medicine.

AAMC is deeply committed to increasing diversity in medical schools in order to increase the number of minority physicians available to help serve the Nation's ever-growing minority population, expand areas of research undertaken by medical academics, and raise the general cultural competence of all physicians. If medical schools cannot consider race or ethnicity in the admissions process, the already low number of minority physicians will decrease to critical levels, leaving this Nation's health care system in a profound state of crisis. AAMC therefore offers its views as *amicus curiae* and respectfully urges the Court to affirm the decision below.

AAMC is joined in this brief by fourteen organizations whose members include schools, residency programs and other institutions involved in educating and training health care providers

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[1] Pursuant to Sup. Ct. R. 37, the undersigned counsel hereby confirm that no counsel for either party authored any portion of this brief, and no person or entity other than the named *amici* has made any monetary contribution to the brief's preparation or submission. Written consent of the parties to allow all interested *amici* to file briefs in this case are on file with the Court.

and administrators: the **American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Association of Colleges of Podiatric Medicine, American Association of Directors of Psychiatric Residency Training, American Dental Education Association, Associated Medical Schools of New York, Association of Academic Health Centers, Association of American Veterinary Medical Colleges, Association of Physician Assistant Programs, Association of Schools of Allied Health Professions, Association of Schools of Public Health, Association of University Programs in Health Administration**, and **Hispanic-Serving Health Professions Schools, Inc.**; thirteen organizations whose members include more than 450,000 physicians and other health care providers: the **American Academy of Family Physicians, American Academy of Orthopaedic Surgeons, American Academy of Pediatrics, American Academy of Physician Assistants, American College of Obstetricians and Gynecologists, American College of Physicians-American Society of Internal Medicine, American Nurses Association, American Psychiatric Association, American Public Health Association, Association of American Indian Physicians, National Hispanic Medical Association, National Medical Association,** and **Society of General Internal Medicine**; two organizations which represent the interests of medical school students: the **American Medical Student Association** and **ASPIRA Association, Inc.**; and **National Medical Fellowships, Inc.**, a non-profit organization that is dedicated to improving the health of underserved communities. Additional information regarding these organizations is provided at App. 1.

SUMMARY OF THE ARGUMENT

Medicine is one of this Nation's greatest resources. Part of the medical profession's strength is its recognition of a moral and social obligation to meet our country's myriad health care needs as comprehensively as possible. This obligation includes not only training a sufficient number of able physicians in different practice areas, but also ensuring that competent medical care is reasonably

available to all citizens. The ongoing ability to fulfill this obligation necessarily falls upon the shoulders of the 126 allopathic medical schools and the 20 osteopathic schools that exist in this country. As gatekeepers to the medical profession, these medical schools must retain the ability to select students who are academically accomplished, morally sound, capable of completing the lengthy process of graduate medical education, and diverse in background and professional interest.

The medical school and health care communities firmly believe that medical schools must take race and ethnicity into account in the admissions process in order to obtain the most effective physician workforce. Empirical studies consistently demonstrate that minority physicians -- notably, African Americans and Hispanics -- are significantly more likely to practice in underserved areas comprised largely of minority and poor populations. They are also more likely to undertake research addressing the unique medical concerns of minority populations. These populations are precisely those that, on average, have the most severe health problems and medical needs.

According to the most recent U.S. census, minority populations now comprise approximately one third of the Nation's entire population. Medical schools have a compelling need to graduate minority physicians in significant numbers to help serve our growing minority populations, to present patients with meaningful consumer choice, to provide health care organizations with a richly varied talent pool of leaders and administrators, and to undertake a broader range of necessary research initiatives. Their inability to do so would result in very real adverse consequences for our society, measurable in terms of human suffering, lost productivity, and enormous health care costs.

In addition to the unique concerns of medicine, medical schools share an interest in diversity that is common to all institutions of higher education. Medical schools strive to produce culturally sensitive individuals who are able to practice their profession within the context of an increasingly multi-cultural society. To achieve this goal, medical students must be educated in environments which reflect the larger society into which the students will graduate. Cultural competence enhances

patient satisfaction and trust, with the result that doctor-patient communication improves, physician decision-making is better informed, and patients are more likely to follow their physicians' advice.

Unless prohibited from doing so under state law or case precedent, virtually all medical schools take race and ethnicity into account as one of many factors to be considered in a competitive admissions process. History has proven this strategy sound. A very high percentage of minority medical students go on to graduate, pass their medical license exams, and pursue successful careers in medicine.

The medical profession is not advocating race-conscious admissions programs as a panacea for the systemic problems confronting medicine or education generally. Taking race and ethnicity into account in admitting students to the study of medicine is only part of a larger strategy involving numerous initiatives to increase the number of underrepresented minorities in medical schools. Hopefully, these initiatives will result in more parity in grade point averages and test scores among all the different populations comprising our citizenry. But until the systemic changes bear fruit, race and ethnicity must continue to play a limited, but critical role in the admissions process.

As access to health care becomes increasingly problematic for the majority of Americans, the need to create a diverse, culturally competent population of trained medical professionals becomes increasingly urgent. Under even the strictest scrutiny, an educational institution's narrowly-tailored race-conscious admissions program should be upheld.

ARGUMENT

As this Court is well aware, this is the first time since *Regents of the Univ. of California v. Bakke*, 438 U.S. 265 (1978), that the Court has considered the propriety of race-conscious admissions programs in higher education. *Bakke*, of course, involved medical school admissions. The Sixth Circuit has concluded that *Bakke* remains binding precedent and that the University of Michigan's law school "has a compelling state interest in achieving a diverse student body." *Grutter v. Bollinger*,

288 F.3d 732, 739 (6th Cir. 2002) (*en banc*). The court also concluded that the law school's admissions policy lawfully fulfills its diversity interest. *See id*. at 752. The legal arguments supporting the vitality of *Bakke* and the specific parameters of the University of Michigan's law school admissions program are set out by counsel for the University and will not be repeated here. Instead, we limit our argument to supporting the Sixth Circuit's broader holding that higher education has a compelling interest in diversifying its student body and may serve this interest with a narrowly-tailored policy that takes race and ethnicity into account in the admissions process. Although petitioner attacks only the admissions policy implemented by the University of Michigan Law School, there is no doubt that the Court's decision will impact the admissions practices of all of higher education. *See, e.g.,* William G. Bowen & Derek Bok, *The Shape of the River: Long Term Consequences of Considering Race in College and University Admissions* 8 (1998).

The unfortunate but inescapable reality is that certain minority candidates for medical school -- namely, African Americans, Native Americans, Mexican Americans and mainland Puerto Ricans -- tend to have lower GPA's and lower scores on the Medical College Admission Test ("MCAT") than white candidates. It is likewise undeniable that, but for the race-conscious admissions policies currently used by medical schools, the already low number of minority students admitted to medical school would fall precipitously. This would have an enormously damaging impact on the delivery of health care in America.

Until such time as our education system allows students from all racial and ethnic backgrounds to compete evenly for the few, selective medical school positions available in this country, there is simply no way to ensure meaningful diversity in medicine without considering race and ethnicity as one factor in the admissions process. *See generally* App. 3, *infra*. Nor is there a downside to doing so in terms of ensuring that medical schools produce fully qualified graduates. The consideration of race and ethnicity has not lowered the quality of physicians emerging into the

workforce. Instead, it has helped to create a culturally sensitive and diverse physician population which is more likely to practice in underserved populations, more likely to conduct needed research in diverse areas of medicine, and more sensitive to important and perhaps fundamental changes in the future direction of public and private health care.

I. OUR SOCIETY HAS A CRITICAL NEED TO GRADUATE COMPETENT MINORITY PHYSICIANS

It is well established that minority populations suffer greater health problems than non-minorities. "Evidence of racial and ethnic disparities in healthcare is, with few exceptions, remarkably consistent across a range of illnesses and health care services." *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* 5 (Brian D. Smedley et al. eds., Institute of Medicine, The National Academies Press, 2003) (hereinafter "*Unequal Treatment*"); *see also* Raynard Kington et al., *Increasing Racial and Ethnic Diversity Among Physicians: An Intervention to Address Health Disparities*, in *The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in the Health Professions* 57, 61-62 (Brian D. Smedley et al. eds., Institute of Medicine, National Academy Press, 2001) (hereinafter *"Enhancing Diversity in the Health Professions"*) (minorities have higher hospitalization and mortality rates than whites even after adjusting for income). For example,

> African Americans still experience a lower life expectancy at birth and a higher average age-adjusted all-cause death rate than Whites. African Americans also experience higher death rates for many conditions, including coronary disease, stroke, and cancer, and infant mortality rates are higher among both African-American and American Indian/Alaska Native populations than among Whites and most Hispanic subpopulations.

Id. at 58 (citations omitted); *see generally* Minority Health & Health Disparities Research & Education Act of 2000, 42 U.S.C. § 281 *et seq*. (establishing a National Center for Minority Health and Health Disparities).

Despite being less healthy and more at risk than other populations, minorities tend to receive "differential and less optimal technical care than white Americans." Lisa Cooper-Patrick et al., *Race, Gender, and Partnership in the Patient-Physician Relationship*, 282 JAMA 583, 583 (1999). This is particularly true for minorities living in underserved rural and inner-city areas, where "[a]n estimated 50 million people live," and an additional "13,000 physicians" are needed to serve their needs. *Training the Health Workforce of Tomorrow*, Issue Brief No. 12 (Grant Makers in Health, Washington, D.C. 2002), at 2 (hereinafter, "*Training the Health Workforce*"); *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 (1996) (urban areas of poverty with high proportions of African American or Hispanics had nearly three times fewer physicians per capita as other comparable areas, and supply of physicians in rural areas is likewise inversely associated with the proportion of African American or Hispanic residents). The existing health care disparities in this country will only increase as minority populations grow. *See generally* Herbert W. Nickens & Jordan J. Cohen, *On Affirmative Action*, 275 JAMA 572, 572 (1996); *Training the Health Workforce*, *supra,* at 8.

The health disparities experienced by minorities raise fundamental concerns regarding access to health care in our country. The disparities result in widespread human suffering and loss – much of it preventable. There are also enormous financial consequences. Indeed, the problems are so acute that, in 1998, a $400 million initiative was undertaken by the federal government to help address racial and ethnic disparities in six key health areas which are amenable to intervention (infant mortality, diabetes, cancer screening and management, heart disease, HIV infection, and child and adult immunizations). *See* Office of Minority Health, U.S. Dep't of Health & Human Services, *Assessment of State Minority Health Infrastructure and Capacity to Address Issues of Health Disparity*, Sec. 1D at 1 (July 3, 2001), *available at* www.omhrc.gov/omh/sidebar/

cossmo/sec_1D.htm (hereinafter "*HHS Assessment of Minority Health Infrastructure*"). In one of the six targeted areas alone -- cardiovascular disease (CVD) -- a subsequent HHS report quantified the annual economic consequences as follows:

> The annual national economic impact of CVD nationwide as measured in health care expenditures, medications, and lost productivity due to disability and death is estimated at ***$274 billion***.

HHS, *Race Initiative Summary Report on Cardiovascular Disease*, at 2 (2000) (emphasis added), *available at* www.raceandhealth.hhs.gov/3rdpg6blue/cardio/cvdrep122/pdf. HHS went on to note that the death rate due to CVD is 49% higher for African American men and 67% higher for African American women than for white men and white women, respectively; and that Hispanics, Native Americans and Asians/Pacific Islanders also experience high death rates due to CVD. *See id.*

There is a compelling need to address these health care disparities. Through their admissions policies, medical schools play a critical role in that process.

A. Minority Physicians Are More Willing To Practice In Underserved Population Areas

In *Bakke*, this Court rejected the notion that the Medical School of the University of California at Davis needed to take race and ethnicity into account in its admissions process in order to improve the delivery of health-care services to underserved communities. 438 U.S. at 310. Justice Powell, who was the only Justice directly to address this justification for the school's race-conscious admissions program, concluded that there was a dearth of information supporting the belief that minority physicians were more likely than non-minorities to practice in underserved areas of the country. *See id.* Quoting the state court below, Justice Powell noted that "there is no empirical data to demonstrate that any one race is more selflessly socially oriented or by contrast that another is more selfishly acquisitive." *Id.* at 311 (citation omitted).

The same cannot be said today. Since 1978, numerous studies have demonstrated that minority physicians are more likely than their non-minority counterparts to serve minority

populations. *See, e.g.,* Stephen N. Keith et al., *Effects of Affirmative Action in Medical Schools: A Study of the Class of 1975*, 313 New Eng. J. Med. 1519, 1524 (1985) (demonstrating that minority physicians are more likely to serve minority patients even when controlling for premedical school performance and socioeconomic backgrounds); Earnest Moy & Barbara A. Bartman, *Physician Race and Care of Minority and Medically Indigent Patients*, 273 JAMA 1515, 1517 (1995) (revealing that minority patients were over four times more likely to receive care from non-white physicians than were Caucasian patients); Komaromy, *supra,* at 1305 (abstract) (in California, "[African-American] physicians practiced in areas where the percentage of African-Americans was nearly five times as high, on average, as in areas where other physicians practiced[, and most] Hispanic physicians practiced in areas where the percentage of Hispanic residents was twice as high as in areas where other physicians practiced"); Somnath Saha et al., *Patient-Physician Racial Concordance and the Perceived Quality and Use of Health Care*, 159 ARCH Intern. Med. 997, 1000 (1999) (hereinafter "Saha, *Patient-Physician Concordance*") ("[A]lthough black physicians account for less than 5% of the total U.S. physician workforce, they served as regular health care providers for 23% of the black individuals in [the study] sample."). Minority physicians are also more likely to enter into primary care specialties, to practice in underserved areas, and to serve uninsured and Medicaid patients, regardless of the patients' race or ethnicity. *See, e.g.,* Keith, *supra,* at 1524; Moy & Bartman, *supra*, at 1517; Komaromy, *supra*, at 1308-09; Joel C. Cantor et al., *Physician Service to the Underserved: Implications for Affirmative Action in Medical Education*, 33 Inquiry 167, 173 (1996); *see also* Kington, *supra*, at 85 ("Strong, compelling evidence suggests that minority physicians are indeed more likely to provide precisely those services that may be most likely to reduce racial and ethnic health disparities, namely primary care services for underserved poor and minority populations.").

Recognizing the greater propensity of minorities to practice in underserved population areas, Congress has funded scholarship programs targeted towards disadvantaged and minority individuals

interested in health care professions. *See* Comm. on Labor & Human Resources, *Health Professions Education Partnership Act of 1998*, S. Rep. No. 105-220, at 20 (1998) ("The committee recognizes the benefits of training greater numbers of individuals from disadvantaged and minority backgrounds. Such individuals tend to enter primary care practice and practice in underserved areas to a much greater degree than others."); *see also* 42 U.S.C. § 300u-6 note (Congressional Findings for the Disadvantaged Minority Health Improvement Act of 1990). Likewise, the Department of Health and Human Services has recommended increasing underrepresented racial and ethnic groups in the health professions "as an integral part of the solution to improving access to care." *Healthy People 2010: Objectives for Improving Health*, Part A, Focus Area 1, Objective 1-8 (HHS, 2d ed. Nov. 2000), *available at* www.healthypeople.gov/Document/HTML/Volume1/01 Access. htm); *see also HHS Assessment of Minority Health Infrastructure, supra,* Sec. 4D at 1 *("*[U]nderrepresentation of minorities in health professions is a major concern affecting the delivery of health care services to racial and ethnic minorities.").

Thus, it is now well documented that diversity in medical education provides improved access to health care for underserved populations. Given the health care crisis facing our Nation with respect to these populations, this evidence alone provides a compelling reason for medical schools to consider race and ethnicity in their admissions processes.[2]

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[2] The *amici* do not mean to imply that minority physicians should or will be limited to serving only minority or underserved populations. To the contrary, the evidence indicates that minority physicians practice in all specialties and across racial and ethnic populations. *See* Keith, *supra,* at 1524. Our point is simply that neither the medical schools nor this Court should ignore the documented reality that a greater proportion of minority physicians tend to serve minority and underserved populations than is true of non-minorities, and that this fills a real and pressing need within our health care system.

B. Patient Satisfaction Is Integral To Effective Health Care, And Minority Patients Are Often More Comfortable With Physicians Of Their Own Race

Other compelling reasons also support the need for diversity in medical school admissions. For instance, empirical studies indicate that minority patients express greater reluctance to accept physician recommendations or seek medical care than their white counterparts. *Unequal Treatment, supra,* at 131. When given the choice, these same patients tend to choose, and be more satisfied with, physicians of their own race or ethnic background. *See, e.g.,* Somnath Saha et al., *Do Patients Choose Physicians of Their Own Race?*, 19 Health Aff. 76, 77 (2000) (hereinafter "Saha, *Do Patients Choose*"); Cooper-Patrick, *supra*, at 587; *see also HHS Assessment of Minority Health Infrastructure*, *supra*, Sec. 4D at 1 ("Studies have found that trust in the health care delivery system increases if patients see that at least some of the health care providers are members of the patients' racial or ethnic group.").

This preference may be due to language and cultural similarities. *See* Saha, *Patient-Physician Concordance*, *supra,* at 1002. Or, in the case of African Americans, racial preference may also be the result of a general distrust of "health professions that stems from racial discrimination and the history of segregated, inferior care for minorities." *Unequal Treatment, supra,* at 131. Whatever the reason, it is clear that patient satisfaction with their physicians promotes effective health care. Research indicates that increasing minority patient satisfaction with their physicians will make minorities more likely to seek preventive care, to follow a physician's recommendation, and to continue with necessary treatment. *See* Saha, *Patient-Physician Concordance*, *supra,* at 1000.

This is not to say that patients should always have physicians of their own race or ethnicity, or that only minority physicians can deliver effective care to minority patients. To the contrary, while there is well recognized need to promote the "cultural competency" of all physicians, *see* pp. 13-16, *infra*, minority patients obviously can and do receive effective care from physicians of all races, as do white patients. However, responding to consumer choice, particularly when it helps to

increase patient satisfaction among those with the greatest need for improved health care, constitutes another significant justification for the consideration of race and ethnicity in the admissions process. *See id.*; *cf. Reynolds v. City of Chicago*, 296 F.3d 524, 529-31 (7th Cir. 2002) (City had a "compelling justification to increase the number of Hispanic lieutenants" in its police department, where roughly 20% of the City's population was Hispanic and the evidence showed that this population responded more positively to Hispanic policemen); *Wittmer v. Peters*, 87 F.3d 916, 920-21 (7th Cir. 1996) (prison had compelling justification for hiring black lieutenant where evidence showed that black prisoners would respond more positively to him and prison would be more likely to fulfill its mission of rehabilitation), *cert. denied,* 519 U.S. 1111 (1997).

C. Increasing The Number Of Minority Physicians Will Help To Inform The Nation's Medical Research Agenda

A third significant justification for assuring that minorities are sufficiently represented in medicine is the need to broaden and strengthen our nation's health care research agenda. Many unsolved health problems disproportionately affect minority populations. *See* Kington, *supra*, at 58. However, the national research agenda

> is set in large measure by those who have chosen careers in investigation. Individual investigators, in turn, tend to do research on problems that they "see" and have an interest in. And what people see, what excites their curiosity, depends to a great extent on their personal cultural and ethnic filters.

Jordan J. Cohen et al., *The Case for Diversity in the Health Care Workforce*, 21 Health Aff. 90, 94 (2002) (hereinafter, "Cohen, *The Case for Diversity*"). As a result, "research conducted by minorities in academia often focuses on health issues or diseases that have a disproportionate impact on racial and ethnic populations." *Training the Health Workforce, supra,* at 10.

Recognizing the need for more diversity among medical researchers, *see* 42 U.S.C. § 287c-31 note, the federal government has authorized funding to support the training of "members of minority health disparity populations or other health disparity populations as professionals in the area of

biomedical or behavioral research or both." Minority Health & Health Disparities Research & Education Act of 2000, 42 U.S.C. § 287c-32(b)(1). This is a wise investment of resources. As the National Institutes of Health has noted, "[o]ur ability to sustain and even increase the momentum of recent scientific progress and our international leadership in medical research depends on recruitment, training, support and retention of diverse biomedical investigators." *NIH Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities* at 29, *available at* www.nih.gov/about/hd/strategicplan.pdf. Simply stated, diversity in medical schools leads to diversity in medical research.

II. A DIVERSE STUDENT BODY HELPS TO CREATE "CULTURALLY COMPETENT" PHYSICIANS AND HEALTH CARE MANAGERS

"[M]uch of the point of education is to teach students how others think and to help them understand different points of view – to teach students how to be sovereign, responsible, and informed citizens in a heterogeneous democracy." Akhil Reed Amar & Neal Kumar Katyal, *Bakke's Fate*, 43 UCLA L. Rev. 1745, 1774 (1996); *see also* Lisa Tedesco, *The Role of Diversity in the Training of Health Professionals*, in *Enhancing Diversity in the Health Professions, supra,* 36, 50 (a diverse classroom "provide[s] a unique contribution to learning, discussion, and understanding that is not necessarily attainable elsewhere").

As former Harvard University President Neil Rudenstine has noted, "'diversity is not an end in itself, or a pleasant but dispensable accessory. It is the substance from which much human learning, understanding, and wisdom derive. It offers one of the most powerful ways of creating the intellectual energy and robustness that lead to greater knowledge . . . .'" Note, *An Evidentiary Framework for Diversity as a Compelling Interest in Higher Education*, 109 Harv. L. Rev. 1357, 1372-73 (1996) (quoting *The President's Report* 1993-95). Students who are exposed to racial diversity in education have a greater ability to understand and consider multiple perspectives; greater satisfaction with their educational experience; and greater tolerance and less prejudice, in the

educational setting and beyond. *See, e.g.,* Bowen & Bok, *supra*, at 218-55; Marvin P. Dawkins & Jomills Henry Braddock II, *The Continuing Significance of Desegregation: School Racial Composition and African American Inclusion in American Society*, 63 J. of Negro Educ. 394, 403 (1994); A. Austin, *Diversity and Multiculturalism on the Campus: How Are Students Affected?*, 25 Change 44, 45-46 (Mar./Apr. 1993).

The petitioner apparently acknowledges that racial diversity in education can provide "laudable" benefits, *Grutter v. Bollinger,* 137 F. Supp. 2d 821, 850 (E.D. Mich. 2001), as does the Solicitor General. *See* Brief for the United States as Amicus Curiae Supporting Petitioner, *Grutter v. Bollinger,* at 9-10 ("Measures that ensure diversity, accessibility and opportunity are important components of government's responsibility to its citizens").

A. Classroom Diversity Leads To More Effective Clinicians

Of course, the benefits of diversity are not limited to undergraduate schools. As Justice Powell recognized in *Bakke*, diversity benefits medical school students as well. 438 U.S. at 313. Congress has so found. *See* 42 U.S.C. § 300u-6 note ("diversity in the faculty and student body of health professions schools enhances the quality of education for all students attending the schools") (Congressional finding (12)); *see also* Dean K. Whitla et al., *Educational Benefits of Diversity in Medical School*, 78 Academic Med., Issue 5 (May 2003) (forthcoming) (manuscript at 18, on file with AAMC) (reporting that, in a survey involving 639 respondents who were enrolled in medical school at Harvard and the University of California, San Francisco, students "overwhelmingly supported affirmative action in admissions" and "strongly believed that diversity enhanced their educational experiences" in ways that will improve their ability to provide medical services in a "multicultural society"). Diversity in medical school translates into more effective and "culturally competent" physicians who are better prepared to serve a varied patient population.

As we have already discussed, minority populations have greater health care problems than the majority population, but use the health care system less. Although some of these disparities are explained by lack of insurance and a shortage of physicians to work in underserved areas, these explanations are only part of the answer. Studies document that health care's racial imbalance may also be "partially attributable to racial, cultural and communication barriers" between physicians and patients. Saha, *Patient-Physician Concordance*, *supra,* at 997; *see also* Cooper-Patrick, *supra*, at 583, 588; Tedesco, *supra,* at 46. These barriers "can contribute to patient noncompliance, premature ends to treatment, poor follow-up and non-optimal treatment outcomes." Tedesco, *supra*, at 47; *see also HHS Assessment of Minority Health Infrastructure*, *supra*, Exec. Summary at 1 (identifying "cultural competence" as one of four "cross-cutting issues" that impact the ability of medical providers to address the health disparities experienced by minorities).

To prepare all medical students, majority and minority alike, to serve an increasingly diverse patient population, medical schools must expose them to "cross-cultural education." *Unequal Treatment, supra,* at 201. In other words, students must become aware of "sociocultural influences on health beliefs and behaviors" and learn the skills necessary to cope with these influences within the context of the patient/physician relationship. *Unequal Treatment*, *supra*, at 201. Greater cultural competence might also help to dismantle the current concordance between a patient's race and his or her preference for a physician of the same race. *See* Saha, *Patient-Physician Concordance*, *supra,* at 1003. The need for such cultural competence is so great that HHS has developed a set of national "cultural competence" standards whose aim is to "contribute to the elimination of racial and ethnic health disparities," and which include, as one standard, the need for health care organizations to "Implement Strategies to Recruit, Retain, and Promote at All Levels of the Organization a Diverse Staff and Leadership That Are Representative of the Demographic Characteristics of the Service Area." *See* 65 Fed. Reg. 80,865, 80,873, 80,874 (Dec. 22, 2000).

As the above studies document, students cannot gain cultural competence through a targeted curriculum alone. Interaction with a diverse set of faculty and peers is vital. Only by encountering and interacting with others from different life experiences can students transcend their own viewpoints and see the world from a different perspective.

B. Classroom Diversity Helps To Bring Creative Thinking And Expanded Perspectives To Health Care Management Issues

Finally, medical schools must ensure that they provide the Nation with an appropriate workforce from which to recruit key managers and leaders who will shape the future of national health care and health care policy. Medical managers should be sensitive to the myriad health care issues facing our Nation as a whole. "[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 people." *Bakke*, 438 U.S. at 313 (Powell, J.). It is a reality of American society that race almost always affects an individual's life experiences and perspectives, and, therefore, what one brings to a learning environment. Note, *The Wisdom and Constitutionality of Race-Based Decision-Making in Higher Education Admissions Programs: A Critical Look at* Hopwood v. Texas, 48 Case W. Res. L. Rev. 133, 160-61 (1998).

Moreover, "[a]s is the case for virtually all sectors of the U.S. economy, it is simply smart business for health care organizations to draw their leadership from a richly diverse talent pool, adequately reflecting the gender, racial, and ethnic melange of the country." Cohen, *The Case for Diversity*, *supra*, at 95. A race-conscious admissions program brings future managers into contact with alternative viewpoints and provides a broader base for selecting individuals who reflect the racial make-up of our country.

III. AN ADMISSIONS POLICY THAT CONSIDERS RACE AS ONE OF MANY FACTORS IS NARROWLY TAILORED TO MEET MEDICINE'S DIVERSITY NEEDS

Given the relatively small number of medical schools in this country, competition to study medicine is fierce. At the same time, the burden on these few schools to create a medical workforce that fills all the needs of our Nation is substantial. Medical schools believe very strongly that race and ethnicity must be considered as one of many factors relevant to an individual's admission into medical school. *See, e.g.,* Charles Terrell, *Foreword* to Association of American Medical Colleges, *Minority Student Opportunities in United States Medical Schools*, (Lily May I. Johnson ed. 2002) (on file with AAMC). No other alternative yields the same diversity benefits as direct consideration of race and ethnicity in the admissions process.

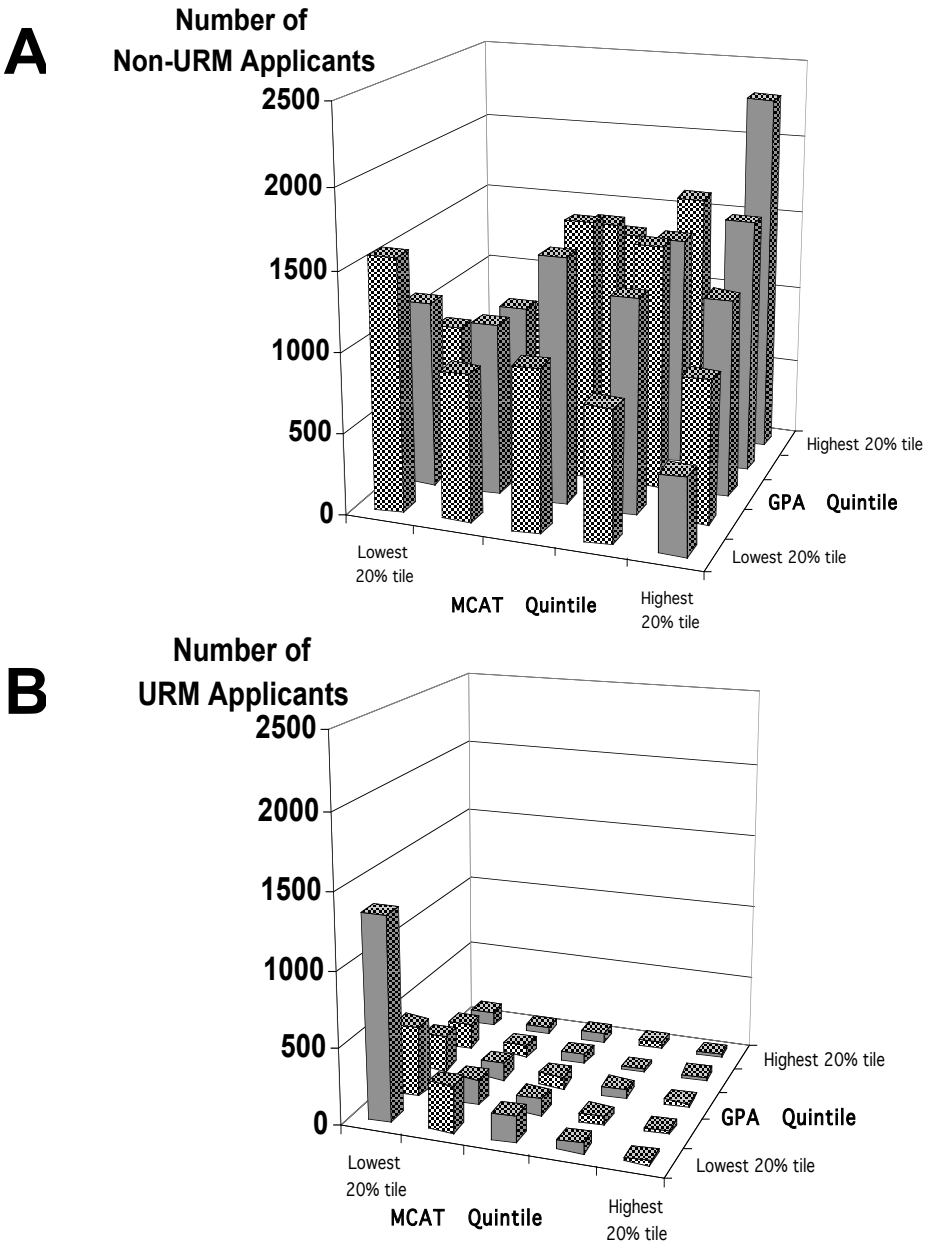
A. Relying On MCAT Scores And GPA's Alone Would Have Disastrous Consequences For Minority Enrollment In Medical School

Standardized test scores and undergraduate grade point averages serve a useful and important role in predicting academic success in medical school. *See, e.g.*, R. Jones & S. Vanyur, *Datagram: MCAT Scores and Student Progress in Medical School*, 59 J. Med. Educ. 527, 530-31 (1984). Most medical schools therefore place significant emphasis on standardized test scores and GPA's when making admissions decisions. *See generally* Michael T. Nettles & Catherine M. Millett, *Toward Diverse Student Representation and Higher Achievement in Higher Levels of the American Educational Meritocracy*, in *Enhancing Diversity in Health Professions, supra,* at 143. However, medical schools also recognize that MCAT scores and GPA's do not wholly predict an individual's chance for success in medical school (much less who will be our most capable physicians). *See* Jones & Vanyur, *supra*, at 531; *Questions and Answers on Affirmative Action in Medical Education* (AAMC, Washington, D.C. Apr. 1998), at 5 (on file with AAMC) (hereinafter "*Questions and Answers*"). Therefore, medical schools have never relied on objective numbers alone in selecting their student bodies. *See* Filomeno Maldonado, *Rethinking the Admissions Process: Evaluation*

Techniques That Promote Inclusiveness in Admissions Decisions, in *Enhancing Diversity in Health Professions, supra*, 305, 306-07. "Candidate selection, conducted exclusively or predominantly by grades and test scores, [would] create[] an admission system with great potential for overlooking individuals who would, in fact, make superior physicians." American Medical Ass'n Board of Trustees Report 15, *Diversity in Medical Education*, at 3 (June 1999) (*available at* www.ama-assn.org).

Medical schools have historically subjected candidates with adequate academic preparation (as evidenced by college grades and MCAT scores) to a rigorous assessment process, including multiple in-person interviews, letters of recommendations, and personal statements. Admissions committees look for such things as evidence of leadership, overcoming hardship, "participation in service-oriented extracurricular activities, honesty, integrity, willingness to serve others, willingness to serve the underserved, compassion, sensitivity, empathy and the ability to communicate with others." *Questions and Answers*, *supra*, at 3; *see also* Maldonado, *supra*, at 306-07. Since the 1960's, they have also considered a candidate's race. *See Questions and Answers*, *supra*, at 2. Such direct consideration of race is not only appropriate, it is absolutely necessary to achieve the many benefits, already discussed, that a diverse medical school student population offers.

It is well documented that underrepresented minorities -- African Americans, Mexican Americans, mainland Puerto Ricans and Native Americans -- generally do not perform as well on the MCAT as the rest of the population. *See* Nettles & Millett, *supra*, at 159. For example, in the year 2001, the average MCAT scores for white applicants were 9.1 in Verbal Reasoning, 9.2 in Physical Sciences and 9.5 in Biological Sciences; in contrast, the average scores for underrepresented minorities were 6.9, 7.0 and 7.3, respectively. A similar phenomenon is seen in GPA's. The following chart illustrates those disparities:



MCAT scores and GPA's for all 2001 applicants to U.S. medical schools with complete data.
Panel A: applicants other than underrepresented minorities (Non-URM) (n=29,683).
Panel B: underrepresented minority applicants (n=3,979).

This gap is not well understood, but some educators believe that the reasons for lower performance include the "lower quality of schools that minority students attend, stereotypic lower expectations of teachers for minority students, combined with stereotypic lower expectations of students for themselves;" the lingering legacy of discrimination; lower education and academic achievement among minority families; and lower income levels. *Questions and Answers*, *supra,* at 4. Whatever the reasons, however, the inescapable reality is this: if medical schools were to rely only on MCAT scores and an individual's undergraduate GPA, the number of admitted underrepresented minorities would plummet. Underrepresented minorities would have been expected to constitute only 3% of those accepted to enter medical school in 2001, instead of the 11% that was actually observed.[3] In real numbers, this would mean that, out of the 17,00 individuals who were accepted to at least one medical school in the United States in 2001 (from among some 34,500 applicants), the number of underrepresented minorities who were accepted would have decreased from 1,868 to 537 students. *See* App. 2.

A ruling that prohibited schools from considering race or ethnicity could also have the perverse effect of undermining the ability of the four historically black medical schools to pursue their historic missions (Meharry, Howard, Drew and Morehouse), at least to the extent that these

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[3] A no-affirmative-action scenario for medical school admissions was developed by AAMC using total cumulative GPA and total MCAT score (sum of the biological sciences, physical sciences and verbal reasoning tests) to predict the acceptance to medical school. It was based on 2001 admissions data from AAMC's data bank. The model presents the extreme case in its projection of who would have been offered acceptance to medical school, insofar as it only considers total GPA and total MCAT score. The total MCAT score and total GPA of white medical school applicants for 2001 were used as the baseline for this model. The coefficients obtained from white applicants were then applied to all other applicants to compute their probability of acceptance. Acceptance probabilities were then ranked among applicants from the highest (near 100%) to the lowest, and the first 16,710 individuals with the highest probability were then selected as "accepted applicants." The 16,710 figure reflects the number of individuals who were actually accepted in 2001 to at least one medical school in the United States (excluding foreign applicants and those of unknown race/ethnicity).

schools consider race as one factor in their admissions process. *See* Comment*, When a Door Closes, a Window Opens: Do Today's Private Historically Black Colleges and Universities Run Afoul of Conventional Equal Protection Analysis?*, 42 Howard L. J. 469, 499-503 (1999). "It would be ironic, to say the least, if the institutions that sustained blacks during segregation were themselves destroyed in an effort to combat its vestiges." *United States v. Fordice*, 505 U.S. 717, 748-749 (1992) (Thomas, J., concurring) (noting that the Court's opinion did "not foreclose the possibility that there exists 'sound educational justifications' for maintaining historically black colleges *as such*") (original emphasis).

Given the proven benefits of diversity, the real need for more minority physicians, and the absence of any indication that less qualified (much less unqualified) individuals are emerging at the end of the graduate medical education process (a point discussed below), our Nation cannot allow these dismal extrapolations to become reality.

B. Considering Race And Ethnicity In The Application Process Does Not Compromise Physician Competence

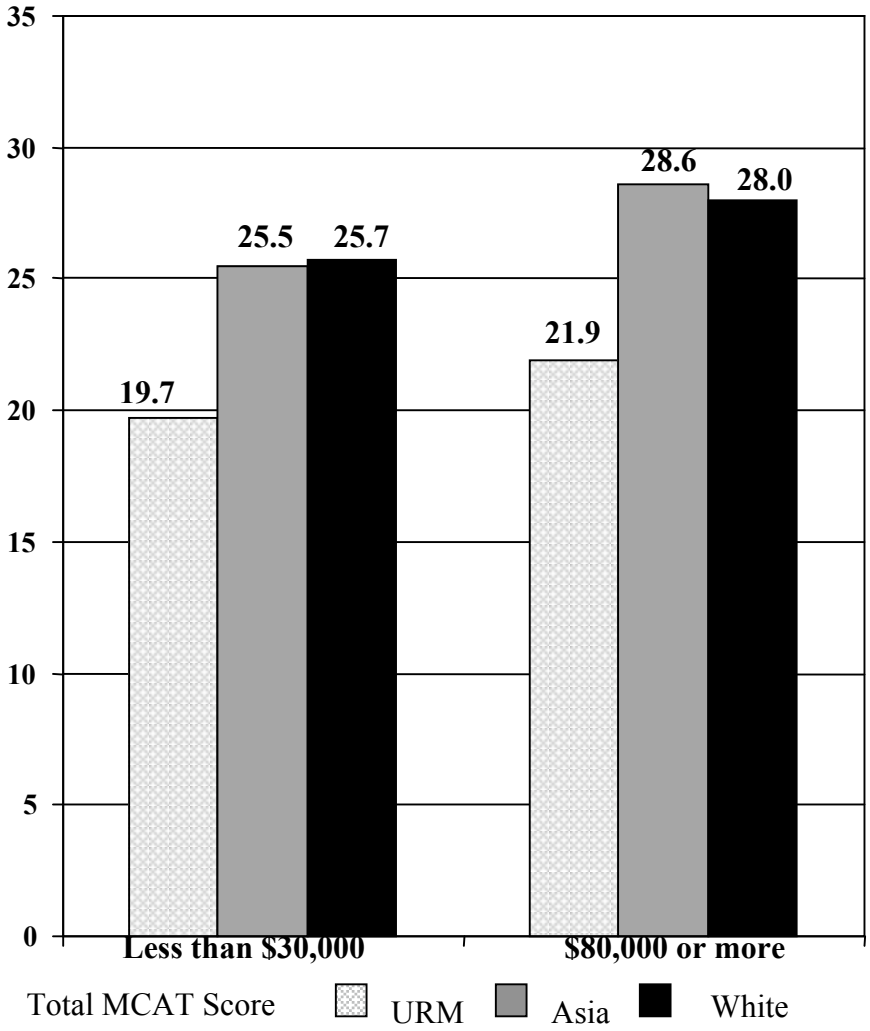
The consideration of race and ethnicity in medical school admissions has not, as some critics suggest, led to a less competent physician workforce. The vast majority of minority medical students graduate from medical school and go on to pass their license examinations. Jordan J. Cohen, *Finishing the Bridge to Diversity,* 72 Academic Medicine 103, 108 (1997); *Questions and Answers*, *supra*, at 3 (noting that, by 1997, 87% percent of minority medical students who matriculated in 1990 had graduated from medical school; and that, by 1996, 88% of African-American and 95% of

Hispanic medical students had passed the three-part national medical school examination). These achievements are the ultimate benchmarks of medical competency. Minority applicants admitted to medical schools succeed, and with this success comes the benefits of diversity to our society as a whole.

C. No Other Factor Yields The Diversity Benefits That Direct Consideration Of Race And Ethnicity Yields

No "race-neutral" factor can effectively substitute for the direct consideration of race in the admissions process. For instance, substituting "economic hardship" for race and ethnicity, as some have suggested, would not address the pressing need to increase the number of minority physicians being trained in America. Studies confirm that the relationship between a physician's race or gender and his or her service to minority and other underserved populations was significantly more pronounced and consistent than the relationship between a physician's socioeconomic background and his or her service to these same population groups. *See* Cantor, *supra,* at 173, 176, 178. Moreover, accounting for economic hardship would not level the admissions playing field for minority and non-minority medical school candidates. In 2001, the average total MCAT score for underrepresented minorities

coming from families with incomes of $80,000 or more was lower than the average MCAT scores of whites and Asians coming from families with incomes of $30,000 or less:


35
30
25
20
15
10
5
0
19.7
25.5
25.7
21.9
28.6
28.0
Less than $30,000
$80,000 or more
Total MCAT Score
URM
Asia
White

The data thus confirms that targeting low-income applicants would not get more minority candidates into medical school and into medicine.

Other proxies for race and ethnicity, such as so-called "percentage plans," would prove equally unsatisfactory. After the Fifth Circuit held in *Hopwood* that higher education could not consider race in its admissions process, the University of Texas implemented a new policy in which it automatically admits the top ten percent of each of the state's high school classes. *See generally* Thomas E. Perez, *Current Legal Status of Affirmative Action Programs in Higher Education*, in *Enhancing Diversity in Health Professions, supra*, 91, 112. However, the success of this policy in increasing minority representation on Texas campuses depends on state education remaining largely segregated; moreover, such a policy cannot be implemented at the graduate school level. *See id.* at 112-13. Medical schools cannot simply admit some specified percentage of all individuals who graduate at the top of their class from some indeterminate universe of undergraduate schools. Even if they could, attempts to achieve diversity under a "percentage plan" system might have the effect of compromising currently high academic standards by lowering the threshold admissions standards without requiring the concomitant subjective attributes that promise future achievement. *See* Bowen & Bok, *supra*, at 271-74; *see also* Ben Wildavsky, *What Happened to Minority Students?,* U.S. News & World Rep., Mar. 22, 1999, at 29 (using high school rank as sole criteria for admissions to achieve diversity in race-neutral manner may have "perverse incentives" such as causing students to take easier classes or to transfer to easier schools).

A recent report by the Texas Higher Education Coordinating Board notes that, despite a variety of efforts to increase diversity, Texas medical schools have made "little progress in enrolling Black and Hispanic students . . . during the last decade," and there is still a pressing need "to increase the number of underrepresented students . . . and thereby increase the number of physicians from underrepresented groups." Tex. Higher Ed. Coord. Bd., *Feasibility Study for Any Institution of*

Higher Education to Provide Clinical Education to Support a Doctor of Medicine Degree Program at Prairie View A&M University, at 31 (Oct. 2002), *available at* www.thecb.state.tx.us. Likewise, in California, which banned affirmative action by way of Proposition 209, the enrollment of underrepresented minorities in the state's medical schools dropped after the ban was put in place and remains at inadequate levels. *See* U.S. Comm'n on Civil Rights, *Beyond Percentage Plans: The Challenge of Equal Opportunity in Higher Education* (Nov. 2002), at 25 (noting that the total number of African American, Hispanic and Native American applicants to the five University of California medical schools dropped from 4,165 in 1995-96 to 2,593 in 2001-2002; and that, "for the 2001-02 school year, the five UC medical schools enrolled an average of four African Americans, nine Hispanics, and no Native Americans each"). And, even if these plans worked, they would inevitably be subjected to the same legal challenges that have brought this case to the Court. *See, e.g.,* Center for Individual Rights, *Alternatives to Affirmative Action* at 1 (noting the post-affirmative action admission systems adopted in Texas, California and Florida, and stating that "Gerrymandering admission standards to produce a certain racial mix poses similar legal problems to explicit preferences, as well as being harmful to the educational mission of colleges and universities."), *available at* www.cir-usa.org/articles/Michigan_alternativeAA.html.

Thus, contrary to what the Solicitor General suggests, *see* Brief for the United States, *supra*, at 17-22, it does not make sense to pursue the acknowledged benefits of diversity through proxies and indirection. Doing so would simply trade a new universe of legal uncertainty and threatened litigation for the unsettled universe now confronting higher education, while producing far less satisfactory outcomes. Direct consideration of race is both intellectually honest and socially imperative.

D. Race-Conscious Admissions Programs Are Only Part Of Academic Medicine's Efforts To Address Minority Underrepresentation In Medicine

It is unfortunate that we are still at a point in our history where underrepresented minority candidates for medical schools simply cannot compete with non-minorities in terms of their MCAT scores and GPA's. The reasons for this are complicated, debatable, and emotionally charged. AAMC and the other *amici* do not pretend to know all the reasons, but they do have an unqualified interest in helping to fix the problem.

Based upon data and experience gathered over many years, the *amici* are absolutely convinced that a large part of the solution lies in permitting medical schools to continue using race-conscious admissions policies. They are also pursuing other initiatives, however, in an effort to address the systemic problems that may contribute to the disparity in the objective qualifications of minority and non-minority medical school applicant pools. AAMC, for example, administers a foundation-supported summer educational enrichment program for underrepresented minorities designed to help students compete successfully for medical school positions. Conducted as twelve member sites, this $4.5 million program reaches nearly 1,400 students each year, many of whom go on to medical school. AAMC also hosts an annual "Minority Student Medical Career Awareness Workshop" for hundreds of high school and college students; works with the The Robert Wood Johnson Foundation, the W.K. Kellogg Foundation, academic health centers, and interested colleges and high schools to identify and nurture potential minority candidates for health professions careers; and provides services and publications specifically for minority students interested in medical schools. Many of the other *amici* have developed and invested in similar programs. In addition, numerous initiatives have been undertaken at the state level, and by individual educational institutions. *See* Tex. Higher Ed. Coord. Bd., *Addendum to: Projecting the Need for Medical Education in Texas: A Report on Efforts to Increase the Number of Underrepresented Students Enrolled at the State's Medical Schools* (Oct. 2002), at Apps. B, C and E (describing outreach efforts

in Texas and other states, but noting that "[t]hese efforts to promote diversity in medical schools will not yield results immediately and should be viewed as long-term strategies"), *available at* www.thecb.state.tx.us/UHRI/ProfSchools/MedAddendum.pdf.

The *amici* fully endorse and actively support race-neutral approaches to improving medical school diversity, but those approaches have not come remotely close, as yet, to achieving the necessary outcomes:

> The facts are clear. In the near term, there is simply no alternative to the use of race-conscious decision making in medical school admission if our society is to have the benefit of a reasonably diverse physician work force. No amount of rhetoric can avoid the demographic reality of a burgeoning underrepresented minority population that, for a variety of reasons, has on average significantly lower levels of academic achievement. If we are precluded from using race-conscious decision making in medical school admissions, then the nation must accept the reality of still more decades in which the physician workforce is incapable of providing an otherwise achievable quality health care for large segments of the American people.

Jordan J. Cohen, *The Consequences of Premature Abandonment of Affirmative Action in Medical School Admissions* at 11 (2003) (article accepted for publication in the March issue of the Journal of the American Medical Association).

IV. THE EDUCATIONAL COMMUNITY'S JUDGMENT THAT THERE IS A COMPELLING NEED TO CONSIDER RACE IN ADMISSIONS IS ENTITLED TO A DEGREE OF DEFERENCE

This case is not about quotas. Nor is it about unqualified individuals getting admitted into schools. It is simply about preserving the ability of schools to consider a broad range of factors -- including race and ethnicity -- when composing their entering classes and, in the case of medical schools, when composing the aggregate future physician workforce.

The belief that racial and ethnic diversity serves an imperative educational purpose that is furthered by narrowly tailored affirmative action policies has extremely wide support in the academic community. *See* Briefs of *Amicus Curiae* filed in support of Respondents. Their judgment in this

regard is entitled to a degree of deference. *See, e.g., Regents of the Univ. of Michigan v. Ewing*, 474 U.S. 214, 225 (1985).

Allowing educators a degree of deference in such matters as student admissions also comports with the First Amendment. Justice Frankfurter, for example, acknowledged the historic independence of educational institutions and set out the "'four essential freedoms' of a university -- to determine for itself on academic grounds who may teach, what may be taught, how it shall be taught, and ***who may be admitted to study***." *Sweezy v. New Hampshire*, 354 U.S. 234, 263 (1957) (Frankfurter, J., concurring) (emphasis added) (citation omitted). Consistent with that reasoning, Justice Powell recognized in *Bakke* that "a countervailing constitutional interest, that of the First Amendment," is implicated in connection with the right of universities "to select those students who will contribute the most to the 'robust exchange of ideas.'" 438 U.S. at 313.

The First Amendment, in combination with the deference historically given to educational decisions, counsel against any broad and sweeping judicial decision to prohibit undergraduate and professional schools from implementing race- and ethnicity-conscious programs designed to promote and obtain diversity. This is true with respect to all post-secondary educational institutions. However, there is heightened urgency in the context of our Nation's medical schools and their ability to produce, in aggregate, a cohort of graduates who are culturally and technically competent to address the health care needs of our increasingly multicultural society.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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APPENDIX 1 - LIST OF *AMICI*

Association of American Medical Colleges - membership includes 125 medical schools, nearly 400 teaching hospitals and health systems, and 92 academic societies with an aggregate membership of approximately 100,000 individuals.

American Association of Colleges of Nursing - represents 570 institutions offering university and four-year college education programs in nursing.

American Association of Colleges of Osteopathic Medicine - represents the Nation's 20 osteopathic medical schools.

American Association of Colleges of Podiatric Medicine - represents six of the seven U.S. colleges of podiatric medicine and over 200 hospitals and organizations that conduct graduate training in podiatric medicine.

American Academy of Family Physicians - represents 94,300 physicians, residents and medical students.

American Academy of Orthopaedic Surgeons - represents 20,000 board-certified orthopaedic surgeons.

American Academy of Pediatrics - represents 57,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists.

American Academy of Physician Assistants - represents over 37,000 student and graduate physician assistants.

American College of Obstetricians and Gynecologists – represents more than 45,000 obstetrician-gynecologists.

American College of Physicians-American Society of Internal Medicine - represents 115,000 internal medicine physicians and medical students.

American Association of Colleges of Pharmacy - represents all 83 U.S. pharmacy colleges and schools, including more than 4,000 faculty, 36,000 students enrolled in professional programs, and 3,600 individuals pursuing graduate studies.

American Association of Directors of Psychiatric Residency Training - represents 525 residency training directors in general (adult) and child and adolescent psychiatry, as well as fellowship directors in geropsychiatry, forensic psychiatry and addiction psychiatry.

American Dental Education Association - represents 56 U.S. dental schools and 10 Canadian dental schools.

American Medical Student Association - represents 40,000 physicians-in-training.

American Nurses Association – represents the interests of 2.7 million registered nurses and has more than 150,000 members through its state associations.

American Psychiatric Association - represents over 38,000 psychiatric physicians from the U.S. and around the globe.

American Public Health Association - represents more than 50,000 members from over 50 occupations of public health.

Associated Medical Schools of New York - represents the 14 medical schools in New York State.

Association of Academic Health Centers - represents more than 100 institutions, including the Nation's primary resources for education in the health professions, biomedical and health services research, and many aspects of patient care.

Association of American Indian Physicians – represents approximately 280 American Indian Physicians.

Association of American Veterinary Medical Colleges – represents all 27 accredited colleges and schools of veterinary medicine in the U.S.

Association of Physician Assistant Programs - represents the Nation's 134 accredited physician assistant educational programs.

Association of Schools of Allied Health Professions - represents 105 institutions which have a wide variety of allied health programs.

Association of Schools of Public Health - represents the deans, faculty, and students of the 32 accredited schools of public health (SPH), as well as programs seeking to become accredited SPH.

Association of University Programs in Health Administration - represents more than 230 colleges, universities, and health care organizations, as well as faculty and individuals, which are dedicated to the improvement of health care delivery through excellence in health administration education.

Hispanic-Serving Health Professions Schools, Inc. - represents 23 medical schools and 3 public health schools.

National Hispanic Medical Association - represents the interests and concerns of 26,000 licensed physicians and 1,800 full-time Hispanic medical faculty dedicated to teaching medical and health services research.

National Medical Association - represents and promotes the interests of physicians and patients of African descent.

National Medical Fellowships, Inc. - provides millions of dollars in need-based scholarships and fellowships, awards and prizes to medical students who are members of the four groups identified as underrepresented in the medical profession, and otherwise works to increase the representation and training of minority physicians, educators, researchers and policymakers.

Society of General Internal Medicine - represents over 2,800 members as an international organization of physicians and others who combine caring for patients with education and/or research.

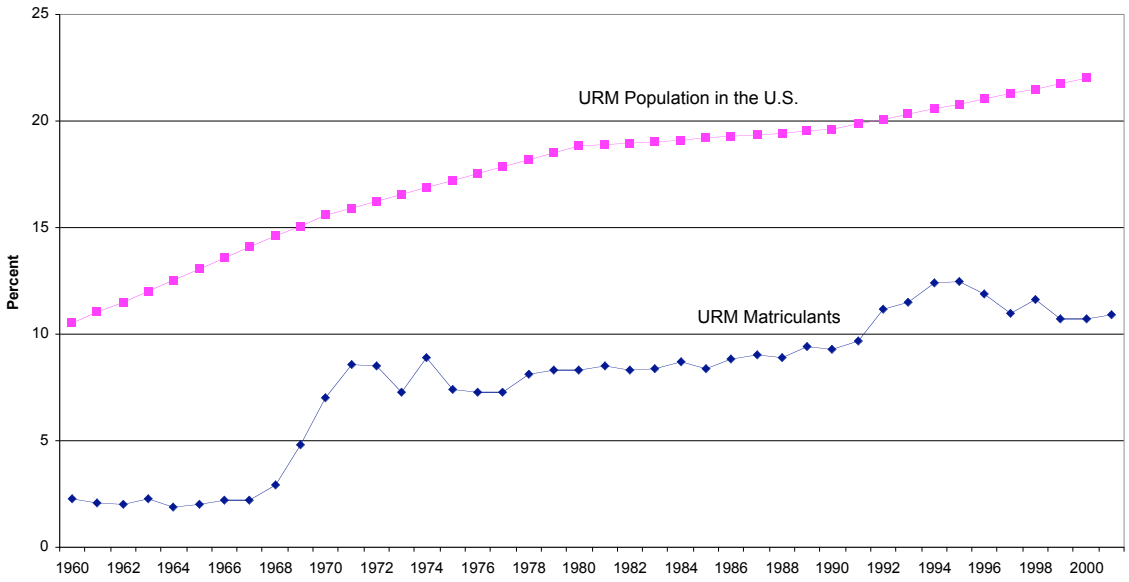
The ASPIRA Association, Inc. – promotes the education and leadership development of Puerto Rican and other Latino youth; works with over 50,000 youth and their families each year.

APPENDIX 2 - COMPARISON OF ACTUAL ACCEPTANCES TO MEDICAL SCHOOLS IN 2001 WITH PROJECTED ACCEPTANCES IF ADMISSIONS HAD BEEN BASED SOLELY ON MCAT SCORES AND GPA'S

	Number of Applicants 2001	Actual Number of Acceptances 2001	Number of Acceptances Under No-Affirmative-Action Scenario
Black	2,885	1,230	288
Mexican American	752	402	136
Native American	263	134	69
Mainland Puerto Rican	195	102	44
Total URM	***4,095***	***1,868***	***537***
White	21,400	11,056	12,063
Asian	6,764	3,457	3,834
Commonwealth Puerto Rican	144	6	20
Other Hispanic	787	323	256
Unknown/Foreign	1,360	494	494
NonURM	***30,455***	***15,336***	***16,667***
Total	34,550	17,204	17,204

This table includes data for all applicants to medical schools in the 50 United States and the District of Columbia for the medical school class entering in 2001. The dependent variable is "accepted at any medical school." Applicants who only applied to the Puerto Rican schools are omitted, because those schools have stringent residency requirements, and most applicants who apply are Puerto Rico residents; therefore, the acceptance picture at those schools would be unlikely to change in the event of a no-affirmative-action scenario. In the model presented, the number of foreign applicants or applicants for whom no race/ethnicity data were available was constrained to the actual number accepted in 2001.

APPENDIX 3 - COMPARISON OF UNDERREPRESENTED MINORITIES IN MEDICAL SCHOOL AND IN THE GENERAL U.S. POPULATION: 1960-2000



This chart illustrates the percentage of underrepresented minorities (URM's) who matriculated to U.S. medical schools from 1960 to 2000. As the chart reflects, medical schools were as segregated as most other institutions in our society prior to the late 1960's: two historically black medical schools (Howard and Meharry) accounted for roughly three-quarters of the small number of blacks able to join the medical profession, while the 85-90 "mainstream" medical schools each enrolled approximately one black student every other year. With affirmative action efforts that began in the late 1960's, the percentage of URM matriculants rose from roughly 2% in 1964 to over 8% by 1971. The percentage of URM matriculants remained relatively constant through the 1970's and 1980's, but the absolute number of such matriculants increased as the number of accredited medical schools rose to 125. Medical schools re-energized their affirmative action efforts in the early 1990's in response to a national call to action occasioned, in part by, AAMC's *Project 3000 by 2000.* This resulted in another sizable increase in the percentage of URM matriculants, as reflected in the chart for the 1990-1995 period. The number of URM matriculants exceeded 2000 in 1995 for the first time in history. That high point, however, was followed by a sharp decline in the percentage of URM matriculants, in the aftermath of *Hopwood* (1996), California's Proposition 209 (1996), and Washington's Initiative 200 (1998). While a positive development, the high point achieved in 1995 still reflects far fewer URM matriculants than the medical community believes to be an adequate number to meet the compelling needs described in the body of this brief.

See generally Jordan J. Cohen, *The Consequences of Premature Abandonment of Affirmative Action in Medical School Admissions*, ___ JAMA ____, at 5-6 (2003) (manuscript) (forthcoming article).