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Enhancing Access to Health Care and Eliminating Racial and Ethnic Disparities in Health Status: A Compelling Case for Health Professions Schools to Implement Race-Conscious Admissions Policies

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ENHANCING ACCESS TO HEALTH CARE AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH STATUS: A COMPELLING CASE FOR HEALTH PROFESSIONS SCHOOLS TO IMPLEMENT RACE-CONSCIOUS ADMISSIONS POLICIES

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INTRODUCTION

Our nation is more diverse than ever, and this diversity is one of our greatest strengths.[1] This demographic transformation presents a host of challenges for the health care system. Although the American health care system is state-of-the art in so many vital respects, it remains separate and unequal for all too many communities of color. Study after study documents persistent racial and ethnic disparities in health status.[2] The consequences can be life and death for people of color, who all too frequently do not have access to quality health care. The stakes are getting higher given the demographic transformation of America, and the adverse health consequences can be observed in urban, suburban, and rural areas across the nation.[3]

The root causes are complex, and the solutions are often elusive. Poverty obviously contributes to racial and ethnic disparities in health status. There are over 46 million people without health insurance in the United States,[4] which

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1. *See* Thomas E. Perez, *Current Legal Status of Affirmative Action Programs in Higher Education*, *in* THE RIGHT THING TO DO, THE SMART THING TO DO: ENHANCING DIVERSITY IN HEALTH PROFESSIONS 91, 93 (Brian D. Smedley et al. eds., 2001) [hereinafter THE RIGHT THING TO DO] (discussing demographic changes in the United States, due in part to an influx of Latino and Asian immigrants).

2. *See* H. Jack Geiger, *Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and Consideration of Causes*, *in* UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 417, 417-19 (Brian D. Smedley et al. eds., 2002) [hereinafter UNEQUAL TREATMENT].

3. *See, e.g.*, SICKNESS & HEALTH IN AMERICA: READINGS IN THE HISTORY OF MEDICINE AND PUBLIC HEALTH 3-4 (Judith Walzer Leavitt & Ronald L. Numbers eds., 2d ed. 1985) (discussing historic demographic trends in national population and the effect on quality of health); U.S. CENSUS BUREAU, DEMOGRAPHIC TRENDS IN THE 20TH CENTURY: CENSUS 2000 SPECIAL REPORTS 1, 71-111 (2002), *available at* http://www.census.gov/prod/2002pubs/censr-4.pdf (showing drastic increases in minority and immigrant populations in the last decade, along with an increase in urbanization).

4. U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004, at 17 fig. 5 (2004), *available at* http://www.census.gov/prod/2005pubs/p60-229.pdf (reporting that in 2004, 14.9% of whites were uninsured, while 19.6% of African Americans and 32.7% of Hispanics were uninsured).

undeniably helps explain racial and ethnic disparities in health status.[5] Geographic or environmental factors (e.g., living on the "wrong" side of the tracks or next to the incinerator) often contribute to disparities.[6] Genetics can sometimes play a role, and discrimination, while sometimes hard to quantify, is difficult to deny.[7]

In recent years, it has become more apparent that the lack of sufficient racial and ethnic diversity in the health professions is a significant factor contributing to racial and ethnic disparities in health status.[8] In 2004, a blue ribbon panel examined racial and ethnic diversity in the health care workforce and concluded that "[t]he fact that the nation's health professions have not kept pace with changing demographics may be an even greater cause of disparities in health access and outcomes than the persistent lack of health insurance for tens of millions of Americans."[9] Increasing racial and ethnic diversity in the health professions is a critical component of a comprehensive strategy to improve access to quality health care in communities of color. An effective way to increase racial and ethnic diversity in the health professions is through the use of race-conscious admissions policies. This article examines a number of legal issues surrounding efforts to increase racial and ethnic diversity in the health professions through the use of race-conscious measures. Currently, as a practical matter, there is only one viable legal theory under which a health professions school can implement race-conscious admissions programs. The so-called "diversity" rationale allows health professions schools to implement narrowly tailored race-conscious admissions programs in order to further the compelling interest in achieving the educational benefits that flow from a diverse student body.[10]

Part One of this article outlines the legal evolution of the diversity rationale by focusing on the legal bookends of the diversity doctrine: the landmark *Bakke* decision in 1978[11] and the more recent *Grutter* case of 2003.[12] Until *Grutter*, the legal landscape surrounding the use of the diversity rationale was muddled. Although the landmark *Bakke* case is over twenty-five years old, and institutions of higher education have relied on *Bakke* to implement race-conscious admissions programs using a diversity rationale, there has been considerable controversy and disagreement about its meaning. In 2003, the United States Supreme Court, by a

5. Geiger, *supra* note 2, at 418; *see also* THE SULLIVAN COMM'N, MISSING PERSONS: MINORITIES IN THE HEALTH PROFESSIONS: A REPORT OF THE SULLIVAN COMMISSION ON DIVERSITY IN THE HEALTHCARE WORKFORCE iv, 1 (2004) [hereinafter SULLIVAN COMM'N REPORT].

6. Geiger, *supra* note 2, at 418.

7. *Id.*

8. SULLIVAN COMM'N REPORT, *supra* note 5, at 1.

9. *Id.*

10. Grutter v. Bollinger, 539 U.S. 306, 343 (2003).

11. Regents of the Univ. of Cal. v. Bakke, 438 U.S. 265, 266-67 (1978).

12. *Grutter*, 539 U.S. at 307.

narrow 5-4 majority, removed the cloud of uncertainty surrounding *Bakke*.[13] The Court in *Grutter* gave a green light to the use of narrowly tailored race-conscious admissions policies in higher education that are designed to further the compelling interest in obtaining the benefits that flow from a diverse student body.[14] Part One discusses *Bakke* and *Grutter* and highlights how the diversity rationale can be bolstered in the health professions context.

Part Two of this article outlines the contours of an additional legal theory to justify race-conscious admissions and recruitment practices in the health professions context. Justice O'Connor authored the landmark decision in *Grutter* and played a crucial role in preserving the viability of *Bakke* and the diversity rationale. Given the fragile 5-4 majority in *Grutter*, Justice O'Connor's recent retirement, and the uncertainty surrounding her successor's views on affirmative action, it is critically important that health professions schools seeking to employ or preserve race-conscious admissions and recruitment policies ensure that their legal marbles are not all in one basket. In short, it is time for health professions schools with race-conscious admissions to purchase an affirmative action insurance policy. Specifically, it is critically important to identify additional legal theories that will support narrowly tailored race-conscious admissions and recruitment policies.

Part Two discusses the proposed "access" rationale for race-conscious admissions and recruitment programs. This approach entails eliminating racial and ethnic disparities in health status and improving access to quality health care in communities of color, which are critical public policy priorities. There is substantial evidence demonstrating that physicians of color are more likely to serve communities of color and more likely to serve low-income, underrepresented communities.[15]

As a result, there is ample empirical evidence to make the case in the health professions context that race-conscious admissions policies will satisfy a compelling interest in increasing access to health care in underserved communities. If health professions schools graduate more students of color, this will reduce the access gap in poor, underserved, minority communities, which in turn will improve the health and well-being of these residents. Part Two outlines the evidence supporting the "access" rationale for race-conscious decision-making in health professions schools, and makes the case that courts should recognize a compelling interest in increasing access to health care in underserved populations that justifies the use of narrowly tailored race-conscious admissions practices in the health professions context.

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13. *Id.* at 310.

14. *Id.* at 343.

15. Raynard Kington et al., *Increasing Racial and Ethnic Diversity Among Physicians: An Intervention to Address Health Disparities?*, *in* THE RIGHT THING TO DO, *supra* note 1, at 64.

Part Three provides a roadmap for health professions schools interested in purchasing affirmative action insurance policies and legal advocates seeking to identify new and viable theories that support race-conscious admissions and recruitment practices.

I. THE EVOLUTION OF RACE-CONSCIOUS ADMISSIONS POLICIES IN HIGHER EDUCATION: FROM *BAKKE* TO *GRUTTER*

Health professions schools in many states have been employing race-conscious admissions policies using the diversity rationale for decades. The contours of these policies are rooted in the landmark *Bakke* decision.[16] There are few Supreme Court decisions whose meaning has been more hotly debated than *Bakke*'s. For instance, when the *Grutter* and *Gratz* affirmative action cases worked their way through the U.S. district court in Michigan, the judge that heard *Grutter* reached a diametrically opposite conclusion about the meaning of *Bakke* from the judge in *Gratz*.[17] There was a split among a number of the circuit courts on the viability of the diversity rationale set forth in *Bakke,* which was an important reason why the Supreme Court heard *Grutter* and *Gratz*.[18] It is important to understand *Bakke,* not simply because Justice Powell's diversity rationale was ultimately upheld by the Court in *Grutter,* but also because the *Bakke* decision itself provides a groundwork for the discussion in Part Two of the "expanding access to health care for underserved populations" rationale for race-conscious policy making.

While there was considerable disagreement until *Grutter* about the precise meaning of *Bakke,* there is no disagreement about the current constitutional standard in affirmative action cases. Courts must employ strict scrutiny when evaluating any racial classifications put into place by a state or other public entity.[19] Thus, in order to justify the use of race or ethnicity in admissions, an institution of higher education bears the burden of demonstrating that the use: (1) serves a compelling governmental interest and (2) is narrowly tailored to the

16. Bakke, 438 U.S. 265.

17. *See* Grutter v. Bollinger, 137 F. Supp. 2d 821, 844 (E.D. Mich. 2001), *rev'd*, 288 F.3d 732 (6th Cir. 2002), *aff'd*, 539 U.S. 306 (2003) (concluding that *Bakke* did not hold that assembly of a racially diverse student body is a compelling government interest); Gratz v. Bollinger, 122 F. Supp. 2d 811, 819 (E.D. Mich. 2000), *rev'd in part*, 539 U.S. 244 (2003) (concluding that the *Bakke* framework allows admissions programs involving competitive consideration of race and ethnic origin).

18. Smith v. Univ. of Wash. Law School, 233 F.3d 1188, 1200 (9th Cir. 2000), *cert. denied,* 532 U.S. 1051 (2001); Hopwood v. Texas, 78 F.3d 932, 944 (5th Cir. 1996), *cert. denied,* 518 U.S. 1033 (1996); Oliver v. Kalamazoo Bd. of Educ., 706 F.2d 757, 763 (6th Cir. 1983); *see also Grutter*, 137 F. Supp. 2d at 855; *Gratz* 122 F. Supp. 2d at 819-31.

19. Adarand Constructors, Inc. v. Pena, 515 U.S. 200, 227 (1995).

achievement of that goal.[20] In other words, for a university seeking to justify the use of race as a factor in admission, the legal bar is high but not insurmountable.

The analysis of any admissions program that allows for the consideration of race or ethnicity thus begins with a discussion of the compelling government interest that the university seeks to serve through the use of race-conscious practices. *Bakke* involved a challenge to the admissions program at University of California at Davis Medical School.[21] The university operated a separate application program for minority applicants, with a separate committee that did not rate the minority applicants against the general applicants.[22] A race-based quota was set for applicants under the special admissions program.[23] The university put forth four reasons for its program: (1) "reducing the historic deficit of traditionally disfavored minorities in medical school and in the medical profession"; (2) "countering the effects of societal discrimination"; (3) "obtaining the benefits that flow from an ethnically diverse student body"; and (4) "improving access to health care for underserved communities."[24]

Allan Bakke, a white male, applied for admission and was rejected.[25] He challenged the program on constitutional grounds and under Title VI of the Civil Rights Act of 1964.[26] The Supreme Court of California upheld his claim and enjoined the state from taking race into account in its admissions program.[27]

The United States Supreme Court affirmed the judgment of the California Supreme Court, holding unconstitutional the particular program put into place by the medical school.[28] There were a number of different opinions written in this case. A five-member majority of the U.S. Supreme Court explicitly reversed the portion of the California Supreme Court's decision that prevented the school from

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20. Grutter v. Bollinger, 539 U.S. 306, 326-27 (2003). A frequently asked question is whether private entities are subject to the same standards as public universities, given that they are not state actors and therefore are not subject to the requirements of the Fourteenth Amendment. The short answer is yes, as long as the institution receives federal financial assistance. Pursuant to Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d (2000), as long as a private university or other entity receives federal financial assistance, it would be required to show that the use of race served a compelling interest and that the program was narrowly tailored to the achievement of that goal. *Bakke*, 438 U.S. at 320. While most of the current affirmative action litigation involves public universities, private universities, virtually all of which receive some form of federal financial assistance and many of which use race or ethnicity as a factor in admissions, have a vested interest in the affirmative action debate. *See Grutter*, 539 U.S. at 323 (2003).

21. *Bakke*, 438 U.S. at 269-70.

22. *Id.* at 272-75.

23. *Id.* at 275. The school determined that of the fifty available positions, eight should be reserved for the special program; when the class doubled to one hundred, so did the number of reserved positions, to sixteen. *Id.*

24. *Id.* at 305-06.

25. *Id.* at 276.

26. *Id.* at 277-78.

27. *Id.* at 279-81.

28. *Id.* at 271.

taking race into account in any fashion in its admissions process.[29] This five-member majority further held that it did *not* violate the equal protection clause for the medical school—even in the absence of any proof of a remedial interest—to take race into account in its admissions process, as long as the program was "properly devised" and involved the "competitive consideration of race."[30] In other words, although the Supreme Court found the particular program in question unconstitutional, it explicitly stated that the school was not precluded from using race in the future, even if there was insufficient evidence of a remedial justification for the use of race-conscious admissions.[31]

Justice Powell, who announced the judgment of the Court, rejected out of hand the "historical deficit" rationale described above. He noted that, "[p]referring members of any one group for no reason other than race or ethnic origin is discrimination for its own sake."[32] He also rejected the "societal discrimination" rationale, calling it "an amorphous concept of injury that may be ageless in its reach into the past."[33] The remedial interest must be much more specific to withstand constitutional scrutiny.

Courts have further narrowed the scope of the remedial rationale.[34] In order to be deemed "compelling," the interest must meet two conditions.[35] First, discrimination must be "identified" discrimination; that is, states "must identify that discrimination, public or private, with some specificity before they may use race-conscious relief."[36] For instance, a state does not have a compelling interest in remedying the present effects of past societal discrimination. Instead, there must be a showing of prior discrimination by the particular government unit involved before a court will permit the use of race-conscious remedies.[37] Despite several Supreme Court opinions, the precise rules for determining how specific and localized the past discrimination must be before a governmental entity can employ race-conscious measures to remedy the effects of past discrimination remain unclear. As a practical matter, the remedial rationale is no longer viable, because the legal bar is simply too high.

Justice Powell's discussion of the diversity rationale has been the portion of the *Bakke* opinion subject to the greatest debate. Justice Powell stated that obtaining the benefits that flow from a diverse student body may be a compelling

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29. *Id.* at 272, 320, 326 (Powell, J.) (Brennan, White, Marshall, and Blackmun, JJ., concurring).

30. *Id.* at 320, 326.

31. *Id.* at 320.

32. *Id.* at 307.

33. *Id.*

34. *See, e.g.*, Podberesky v. Kirwan, 38 F.3d 147, 153 (4th Cir. 1994), *cert. denied*, 514 U.S. 1128 (1995).

35. Shaw v. Hunt, 517 U.S. 899, 909 (1996).

36. *Id.* (quoting Croson v. City of Richmond, 488 U.S. 469, 500, 504-5, 507, 509 (1989)).

37. *Croson*, 488 U.S. at 504.

interest justifying the use of a race-conscious admission program. Justice Powell noted that "an otherwise qualified . . . student with a particular background—whether it be ethnic, geographic, culturally advantaged or disadvantaged—may bring to a professional school . . . experiences, outlooks, and ideas that enrich the training of its student body and better equip its graduates."[38] Justice Powell specifically denounced separate or dual track admissions programs, such as the program implemented by UC-Davis Medical School, because these programs focus solely on racial or ethnic diversity and would "hinder rather than further attainment of genuine diversity."[39]

Justice Powell noted that a key to withstanding constitutional scrutiny is individualized consideration, where race is one of a host of factors under consideration and the individual is considered with all other candidates for the available seats.[40] He cited the undergraduate admissions policy of Harvard University, which considered race as a "plus" in the applicant's file, but looked at other factors and weighed each candidate fairly and competitively.[41] Justice Powell acknowledged that in some circumstances, an applicant's race "may tip the balance in his favor just as geographic origin or a life spent on a farm may tip the balance in other candidates' cases."[42]

Over the next twenty-five years, the most hotly contested question surrounding *Bakke* centered around Justice Powell's pronouncements on the diversity rationale. Specifically, did this portion of the opinion command a majority of the Supreme Court? To put it slightly differently, did a majority of the U.S. Supreme Court hold that diversity can be a compelling state interest in the higher education context justifying the use of narrowly tailored race-conscious admissions programs? Until *Grutter*, courts and commentators disagreed vigorously on the answer to this question.[43]

Three things are clear about *Bakke*. First, a majority of the Supreme Court held that it is permissible for a university to consider race in admissions, even without a history of discrimination by the university.[44] To put it differently, a remedial rationale is backward-looking in the sense that the race-conscious program seeks to correct the effects of past discrimination. The "diversity"

38. *Bakke*, 438 U.S. at 314 (*quoting* Sweatt v. Painter, 339 U.S. 629, 634 (1950)).

39. *Id.* at 315.

40. *Id.* at 317-18.

41. *Id.* at 316-17.

42. *Id.* at 323.

43. *See, e.g.*, Smith v. Univ. of Wash. Law School, 233 F.3d 1188, 1200 (9th Cir. 2000) (asserting that a correct reading of *Bakke* permits educators to "rely upon the [Powell] opinion that gave the decision its life and meaning"); Hopwood v. Texas, 78 F.3d 932, 944 (5th Cir. 1996) (holding that "any consideration of race or ethnicity by the law school for the purpose of achieving a diverse student body is not a compelling interest under the Fourteenth Amendment," and concluding that Justice Powell's argument "never represented the view of the majority of the court in *Bakke* or any other case").

44. *Bakke*, 438 U.S. at 345 (*citing* 45 C.F.R. § 80.5(j) (1977)).

rationale discussed by Justice Powell in *Bakke* is forward-looking in the sense that it seeks to capture the benefits of racial diversity to address emerging societal challenges. Second, no subsequent Supreme Court decision has overturned this critical aspect of the ruling. In fact, Supreme Court Justices on two subsequent occasions have cited *Bakke* for the proposition that diversity may constitute a compelling interest in the higher education context.[45] Third, universities across the country have relied on Justice Powell's opinion for almost a quarter century,[46] and race-conscious admissions programs in higher education are commonplace. The United States Department of Education for a quarter century has relied upon Justice Powell's opinion in issuing guidance to educational institutions that narrowly tailor affirmative action for purposes of attaining a diverse student body so that they are constitutional and comply with Title VI.[47]

It is difficult to conceive of a landmark Supreme Court decision that has been the subject of greater disagreement regarding its meaning and application. For instance, the two federal district court judges for the United States District Court for the Eastern District of Michigan that presided over the two cases involving the admissions policies at the University of Michigan reached diametrically opposite conclusions regarding the meaning and viability of the diversity rationale set forth in *Bakke*.[48]

In the undergraduate case, *Gratz*, the district court ruled that *Bakke* was controlling and stood for the proposition that diversity is a compelling interest justifying the use of a race-conscious remedy.[49] The court explicitly disagreed with the rationale in *Hopwood v. Texas*,[50] and concluded that the university had met its burden of demonstrating that the educational benefits flowing from a racially and ethnically diverse student body constitute a compelling interest justifying the use of race-conscious admissions practices.[51] The district court further found that the current admissions policy was narrowly tailored in that it did

45. Wygant v. Jackson Bd. of Educ., 467 U.S. 267, 386 (1986) (O'Connor, J., concurring); *see also* Metro Broad. Inc. v. FCC, 497 U.S. 547, 568 (1990) (quoting *Bakke*, 438 U.S. at 311-13).

46. John Friedl, *Making a Compelling Case for Diversity in College Admissions*, 61 U. PITT. L. REV. 1, 17 (1999).

47. Guidance on Permissible Admissions Practices in Higher Education, 44 Fed. Reg. 58,509 (Oct. 10, 1979).

48. *See* Grutter v. Bollinger, 137 F. Supp. 2d 821, 844 (E.D. Mich. 2001) (interpreting *Bakke* as holding that desire for racially diverse student body is not a compelling government interest); Gratz v. Bollinger, 122 F. Supp. 2d 811, 820 (E.D. Mich. 2000) (interpreting *Bakke* as holding that desire for racially diverse student body is a compelling interest).

49. *Gratz*, 122 F. Supp. 2d at 820.

50. Hopwood v. Texas, 78 F.3d 932, 944 (5th Cir. 1996) (holding that "any consideration of race or ethnicity . . . for the purpose of achieving a diverse student body is not a compelling interest . . .").

51. *Gratz*, 122 F. Supp. 2d at 820, 822.

not use quotas, ensured individualized consideration, and allowed race to be used as a "plus" in the manner outlined by Justice Powell.[52]

Approximately three months later, a different judge in the law school case, *Grutter*, reached the opposite conclusion. He ruled that diversity is not a compelling state interest and was not recognized as such by a majority of the Supreme Court in *Bakke*.[53] He further ruled that even if diversity was recognized as a compelling state interest, the program was unconstitutional because it was not narrowly tailored and also violated Title VI.[54] The judge found that the law school's current admissions policy was "practically indistinguishable from a quota system."[55]

It took twenty-five years for the Supreme Court to resolve this critical question of the viability of the diversity rationale. The Supreme Court majority in both *Grutter* and *Gratz* adopted the diversity rationale set forth by Justice Powell in *Bakke*. In so doing, the Court cited an extensive body of social scientific and other research documenting the educational benefits of a diverse student body.[56] The *Grutter* Court cited this evidence, strongly endorsed the benefits of student-body diversity, and offered a number of reasons why diversity may be important, including:

- Promoting cross-racial understanding;
- Helping to break down racial sterotypes;
- Helping to break down racial sterotypes;
- Promoting richer classroom learning because "'classroom discussion is livelier, more spirited, and simply more enlightened and interesting' when the students have 'the greatest possible variety of backgrounds'";[57]
- Better preparing students for an increasingly diverse workforce and society;[58] and
- Helping to develop a diverse, racially integrated leadership class.[59]

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52. *Id.* at 816, 826.

53. *Grutter*, 137 F. Supp. 2d at 844.

54. *Id.* at 853; 42 U.S.C. § 2000d (2000).

55. *Grutter*, 137 F. Supp. 2d at 851.

56. *See generally* WILLIAM G. BOWEN & DEREK BOK, THE SHAPE OF THE RIVER: LONG-TERM CONSEQUENCES OF CONSIDERING RACE IN COLLEGE AND UNIVERSITY ADMISSIONS 218-55 (1998) (citing studies that emphasize the importance of diversity in undergraduate education); Mitchell J. Chang, *The Positive Educational Effects of Racial Diversity on Campus*, *in* DIVERSITY CHALLENGED: EVIDENCE ON THE IMPACT OF AFFIRMATIVE ACTION 175, 175-86 (Gary Orfield with Michal Kurlaender ed., 2001) [hereinafter DIVERSITY CHALLENGED] (reporting on one study that suggests that "socializing across racial lines . . . . are positive educational experiences.").

57. Grutter v. Bollinger, 539 U.S. 306, 330 (2003) (citing *Grutter*, 137 F. Supp 2d at 849).

58. *Id.* (citing Brief for American Educational Research Ass'n et al. as Amici Curiae Supporting Respondents at 3, Grutter v. Bollinger, 539 U.S. 306 (2003) (No. 02-241)).

59. *Id.* at 332-33 ("[U]niversities . . . represent the training ground for a large number of our Nation's leaders. . . . In order to cultivate a set of leaders with legitimacy in the eyes of the citizenry, it

These justifications are not unique to a law school or an undergraduate school setting. They can apply equally well to the health professions context. For instance, given the demographic transformation of America, it is more important than ever to have a health care workforce that is culturally competent.[60] A racially and ethnically diverse health professions school can be beneficial to minority and non-minority students alike. A racially and ethnically diverse student body is particularly important given the segregation patterns across America. In *Gratz* and *Grutter*, for instance, data was presented documenting the alarmingly high percentage of students entering the University of Michigan who had little or no meaningful contact with a person of a different race or ethnicity.[61] For these students, the university setting was the first meaningful exposure to persons of different racial and ethnic backgrounds. It is extremely critical in this setting to ensure that students have meaningful cross-racial and cross-cultural interaction, especially since for many it is the first sustained interaction.

In the health care setting, as in other settings, the benefits of diversity are "not theoretical but real."[62] A health care workforce educated in a racially diverse environment is better prepared to meet the needs of a racially diverse society. In the health professions context, there is some research suggesting that medical students bring racial biases with them to medical school. One study involved a group of medical students who viewed a video of an African American woman and a white man presenting identical symptoms of angina.[63] The minority students' perceptions of the health state of the two simulated patients did not differ.[64] However, the non-minority students rated the health problem described by the African American patient as less severe than that described by the white patient.[65] The lesson of this study is really quite simple: medical students are human and

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is necessary that the path to leadership be visibly open to talented and qualified individuals of every race and ethnicity.").

60. *See generally* SULLIVAN COMM'N REPORT, *supra* note 5, at 13-28 ("increasing diversity in health care professions will improve health care access and quality for minority patients and assure a sound health care system for all our nation's citizens").

61. Brief for General Motors Corp. as Amicus Curiae Supporting Respondents at 19, *Grutter*, 539 U.S. 306 (2003) (Nos. 02-241, 02-516), *in* 321 LANDMARK BRIEFS AND ARGUMENTS OF THE SUPREME COURT OF THE UNITED STATES: CONSTITUTIONAL LAW, 2002 TERM SUPPLEMENT, pt.2, at 884 (Gerhard Casper & Kathleen M. Sullivan eds., 2004) (citing Gary Orfield & Dean Whitla, *Diversity and Legal Education: Student Experiences in Leading Law Schools*, *in* DIVERSITY CHALLENGED, *supra* note 56, at 152-72 (stating that half of the white students at the University of Michigan Law School had little or no interracial contact before beginning college or law school)); Patricia Gurin, *Reports submitted on behalf of the University of Michigan: The Compelling Need for Diversity in Higher Education*, 5 MICH. J. RACE & L. 363, 364 (1999), cited in Grutter v. Bollinger, 137 F. Supp. 2d 821, 850 (E.D. Mich. 2001).

62. *See Grutter*, 539 U.S. at 330.

63. Saif S. Rathore et al., *The Effects of Patient Sex and Race on Medical Students' Ratings of Quality of Life*, 108 AM. J. MED. 561 (2000).

64. *Id.* at 563.

65. *Id.*

bring with them human attributes that are a function of their life experiences, many of which do not involve meaningful cross-cultural interaction.[66]

It is quite easy to understand why so many health professions schools and health professions generally participated so actively in *Grutter* and *Gratz*.[67] The diversity rationale adopted by the Court is tailor-made for the health professions context and has been a lynchpin in the strategies of scores of health professions schools committed to increasing racial and ethnic diversity in the health professions.[68] However, *Grutter* was a razor-thin 5-4 majority, with Justice O'Connor playing a pivotal role.[69] Her retirement raises serious concerns about the long-term viability of the *Grutter/Bakke* framework, because there are some indications that Justice Alito may not be supportive of certain affirmative actions programs or share Justice O'Connor's support for the diversity rationale.[70] As a

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66. Kington et al., *supra* note 15, at 83-84.

67. *See* Brief for the Association of American Medical Colleges et al., as Amici Curiae Supporting Respondents at 1, Grutter v. Bollinger, 539 U.S. 306 (2003) (No. 02-241) [hereinafter AAMC Amicus Brief]. The brief stated:

> 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. . . . 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. *Id.* at 1-3.

The Association of American Medical Colleges includes as members 126 medical schools in the United States alone. For a complete listing of member schools, visit http://services.aamc.org/memberlistings/index.cfm?fuseaction=home.search&search_type=MS (last visited March 30, 2006).

68. AAMC Amicus Brief, *supra* note 67, at 18; *see also* COMM. ON INST. & POLICY-LEVEL STRATEGIES FOR INCREASING THE DIVERSITY OF THE U.S. HEALTH CARE WORKFORCE, BOARD ON HEALTH SCIENCES POLICY, IN THE NATION'S COMPELLING INTEREST: ENSURING DIVERSITY IN THE HEALTH-CARE WORKFORCE 3 (Brian D. Smedley et al. eds. 2004) [hereinafter COMM. ON INST. DIVERSITY] (stating that "[f]ew professional fields will feel the impact of the decision in the *Grutter* case—and the potential influence of greater levels of racial and ethnic diversity—as profoundly as the health professions.").

69. *Grutter*, 539 U.S. at 343 ("[I]n summary, the Equal Protection Clause does not prohibit the Law School's narrowly tailored use of race in admissions decisions to further a compelling interest in obtaining the educational benefits that flow from a diverse student body.").

70. For example, Justice Alito did not directly answer questions about whether he believed that increasing diversity in the classroom is a compelling state interest during his confirmation hearings. Amy Goldstein, *Emphasis Shifts from Rights to Powers*, WASH. POST, Jan. 13, 2006, at A6. In *Wygant v. Jackson Board of Education*, Justice Alito, as an Assistant Solicitor General, submitted a brief in which "he argued that the Constitution prohibits the government from treating people differently based on race or gender merely to achieve diversity." Jo Becker and Dale Russakoff, *Proving His Mettle in*

result, while health professions schools not otherwise precluded by state law can and should employ, or continue to employ, the race-conscious, holistic admissions and recruitment framework set forth in *Grutter*, it is equally important for health professions schools to identify additional bases for employing narrowly tailored race-conscious policies. Part Two builds upon the *Bakke/Grutter* framework to construct a new additional justification for narrowly tailored race-conscious admissions and recruitment policies in health professions schools.

II. THE "HEALTH CARE ACCESS" RATIONALE FOR NARROWLY TAILORED RACE-CONSCIOUS ADMISSIONS AND RECRUITMENT POLICIES IN HEALTH PROFESSIONS SCHOOLS

A. Setting the Stage for Judicial Recognition of the "Health Care Access" Rationale for Race-Conscious Admissions and Recruitment Practices

In the more than twenty-five years since the *Bakke* decision, courts and commentators have focused almost exclusively on Justice Powell's articulation of the diversity rationale and his discussion of the contours of a narrowly tailored admissions policy. Virtually no attention has been given to another rationale that the state articulated to support the policy at issue in *Bakke*. The Court noted in *Bakke* that one rationale articulated by the university to support its program was "increasing the number of physicians who will practice in communities currently underserved . . . ."[71]

The Court's discussion of this rationale was quite brief, but very instructive:

> Petitioner identifies, as another purpose of its program, improving the delivery of health-care services to communities currently underserved. It may be assumed that in some situations a State's interest in facilitating the health care of its citizens is sufficiently compelling to support the use of a suspect classification. But there is virtually no evidence in the record indicating that petitioner's special admissions program is either needed or geared to promote that goal . . . .
>
> Petitioner simply has not carried its burden of demonstrating that it must prefer members of particular ethnic groups over all other individuals in order to promote better health-care delivery to deprived citizens.

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the Reagan Justice Dept., WASH. POST, Jan. 9, 2006, at A1. In addition, he has written about being "'particularly proud' of his contributions to cases in which the Reagan administration had argued before the Supreme Court that 'racial and ethnic quotas should not be allowed.'" Jo Becker and Charles Babington, *No Right to Abortion, Alito Argued; Reagan-Era Papers Show Staunch Conservatism*, WASH. POST, Nov. 15, 2005, at A1.

71. Regents of the Univ. of Cal. v. Bakke, 438 U.S. 265, 306 (1978).

> Indeed, petitioner has not shown that its preferential classification is likely to have any significant effect on the problem.[72]

The Court did not dismiss this rationale out of hand. In fact, the Court noted that "in some situations," a state's interest in increasing access to health care in underserved communities "is sufficiently compelling to support the use of a suspect classification."[73] The Court dismissed this rationale because there was a failure of empirical proof of a relationship between this goal and a special admissions program for certain minority students.[74]

In the twenty-seven years since *Bakke*, a wealth of empirical data has emerged, demonstrating that increasing racial and ethnic diversity in the health professions will increase access to health care in underserved, minority communities and will increase access to health care for people with lower income and worse health status.[75] Given the mountain of evidence documenting racial and ethnic disparities in health status, and the difficulties that minorities and low income populations have accessing health care, government in general and health professions schools in particular have a compelling need to identify and implement programs that will reduce disparities and increase access for communities of color. Race-conscious admissions programs will increase the number of minority health professionals, and this can reduce access gaps in minority communities.

The bulk of the empirical data is in the physician context. This data shows that minority physicians are:

- More likely to be in the primary care field;
- More likely to work in health care physician shortage areas;
- More likely to serve communities of color; and
- More likely to serve Medicaid patients.[76]

B. Primary Care Focus

Increasing access to primary care services has been frequently cited as an important component of an overall strategy to eliminate racial and ethnic disparities in health status.[77] Access to primary care services is the proverbial "ounce of prevention" that all too frequently is lacking in poor, underserved, and minority communities. The need for additional primary care physicians is a

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72. *Id.* at 310-11.

73. *Id.* at 310.

74. *Id.* at 310-11.

75. Kington et al., *supra* note 15, at 57-75 (discussing numerous studies that show minority doctors are more likely to work with minority patients).

76. *Id.* at 64-68, 73.

77. *Id.* at 85.

chronic problem in many pockets across America.[78] The absence of a sufficient number of primary care physicians means that scores of people do not have a regular source of health care and do not receive critical preventive health care. The challenge is most acute in minority communities. For instance, one study focusing on California documented that non-Latino whites have the highest percentage of generalist physicians per 100,000 people.[79] Non-Latino whites have ninety generalist physicians per 100,000, whereas Latino, African American, and Asian residents have 52, 61, and 68, respectively.[80]

Studies demonstrate that minority physicians are substantially more likely to choose a primary care practice specialty than non-minorities. For instance, data from the Association of American Medical Colleges (AAMC) regarding practice patterns of minority graduates of American medical schools indicated that African American, Latino, Native American, and Asian medical school graduates were significantly more likely to be practicing primary care medicine than non-minority medical school graduates.[81]

Another team of researchers, led by Dr. Raynard Kington, who is now Deputy Director of the National Institutes of Health, reviewed the literature in this area and concluded:

> 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. It is the opinion of the authors that the strength of that evidence alone is sufficient to support continued efforts to increase the numbers of physicians from underrepresented minority groups.[82]

Given the chronic shortages of health care providers in so many of these communities, increasing the number of racial and ethnic minorities graduating from health professions schools is an effective and critical strategy for expanding access to primary care health services in underserved communities.

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78. *See* Donald E. Pathman et al., *Retention of Primary Care Physicians in Rural Health Professional Shortage Areas*, 94 AM. J. PUB. HEALTH 1723, 1723, 1728 (2004); Miriam Komaromy et al., *The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations*, 334 NEW ENG. J. MED. 1305, 1307-10 (1996), *cited in* Kington et al., *supra* note 15, at 57, 62, 67, 70.

79. Komaromy et al., *supra* note 78, at 1307-10.

80. *Id.*

81. Kevin Grumbach, Speech for the Ass'n of Am. Med. Colleges: Career Trajectories of URM Medical School Graduates (Oct. 23, 2002) (citing ASS'N OF AM. MED. COLLEGES, MINORITY GRADUATES OF U.S. MEDICAL SCHOOLS: TRENDS, 1950-1998 (2000)).

82. Kington et al., *supra* note 15, at 85.

C. Practice Location and Populations Served

Thousands of communities across the United States have been designated as "Health Professionals Shortage Areas" (HPSA) by the Health Resources Services Administration of the United States Department of Health and Human Services.[83] While these communities are by no means exclusively minority, they are disproportionately minority relative to percentage of population. In California, for instance, there is evidence that physician supply is inversely related to the concentration of African Americans and Latinos in the service area.[84] This troubling inverse correlation appears to exist even after adjusting for community income level, and it exists in both rural and urban pockets of the state.[85]

This chronic access problem is not limited to California and is not limited to the African American and Latino communities.[86] Simply stated, many minority communities have a chronic undersupply of health care professionals, and this reality has an adverse impact on access to health care and contributes to racial and ethnic disparities in health status.[87]

Although the Court in *Bakke* correctly noted the dearth of empirical data examining the practice patterns of minority physicians, researchers in the more than quarter century since *Bakke* have carefully examined practice patterns of minority physicians. The findings have been quite consistent and noteworthy: minority physicians are more likely to practice in underserved communities, and more likely to serve minority communities.[88] Minority physicians have higher percentages of patients who are low income, covered by Medicaid, and sicker.[89]

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83. *See id.;* BUREAU OF HEALTH PROFESSIONS, HEALTH RES. & SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., Shortage Designation, http://bhpr.hrsa.gov/shortage/ (reporting that approximately 20% of the U.S. population resides in one of these "Shortage Areas").

84. Komaromy et al., *supra* note 78, at 1307.

85. Kington et al., *supra* note 15, at 62 (interpreting the results of the Komaromy study, *supra* note 78, at 1307).

86. *E.g.*, UNEQUAL TREATMENT, *supra* note 2, at 29 ("Hispanics, Asian Americans, American Indians and Alaska Natives, and African Americans are less likely than whites to have health insurance, have more difficulty getting healthcare, and have fewer choices in where to receive care."); COMM. ON INST. DIVERSITY, *supra* note 68, at 30 ("[r]elative to nonminority communities, minority neighborhoods tend to face shortages of physicians, yet physicians of color are disproportionately more likely to serve in these communities."); Gabriel Garcia et al., *Increasing Diversity in the Health Professions: A Look at Best Practices in Admissions, in* COMM. ON INST. DIVERSITY, *supra* note 68, at 234-35 ("health professions shortage areas, overwhelmingly, are home to poor and minority communities that lack access to health services and to adequate numbers and types of health-care personnel."); Elizabeth A. Mertz & Kevin Grumbach, *Identifying Communities with Low Dentist Supply in California*, 61 J. PUB. HEALTH DENTISTRY 172, 176 (2001) (finding shortages of dentists in disproportionately minority, low-income, and rural California communities).

87. *See* Kington et al., *supra* note 15, at 57, 62.

88. *Id.* at 64, 73, 85; Komaromy et al., *supra* note 78, at 1308-09.

89. *See* Komaromy et al., *supra* note 78, at 1308-09; *see also* Ernest Moy & Barbara A. Bartman, *Physician Race and Care of Minority and Medically Indigent Patients*, 273 JAMA 1515, 1517 (1995).

For instance, a 1985 study by Keith et al. of medical school graduates from the class of 1975 demonstrated that African American, Latino, and Native American physicians were almost twice as likely to be practicing in a HPSA as non-minority physicians, and were far more likely to be caring for patients of their own race or ethnicity.[90] African American patients comprised 56% of the patient load of African American doctors and 8-14% of the caseload of non-African American physicians.[91] Latinos comprised 30% of the caseload of Latino physicians, and 6% of the caseload of non-Latino white physicians.[92]

A 1996 study by Komaromy et al. focused on practice patterns of physicians in California and reached similar conclusions.[93] African Americans comprised 52% of the caseload of African American physicians, and 9% of the caseload of non-African American physicians.[94] Likewise, Latinos comprised 54% of the caseload of Latino physicians, and 20% of the caseload of non-Latino white physicians.[95] This study controlled for the racial makeup of the community where the physicians practiced, and the findings nonetheless were quite stark and statistically significant.[96]

This study also showed that minority physicians cared for more poor people than non-minority physicians.[97] African American doctors reported that 45% of their patients were Medicaid recipients; Asian physicians reported 30%; Latino physicians reported 24%, and non-Latino white physicians reported 18%.[98]

Both the Keith and Komaromy studies examined whether these practice patterns described above were by choice. Komaromy, for instance, examined minority graduates at the University of California-San Francisco,[99] one of the most selective medical schools in the country. Graduates of UCSF have many career choices, and the researchers found that minority graduates at UCSF had substantially similar practice preferences to minority graduates elsewhere.[100]

A 1987 study of California physicians by Davidson and Montoya again confirmed that minority physicians care for higher percentages of Medicaid patients than non-minority doctors and see higher percentages of minority patients

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90. 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, 1521-22 (1985).

91. *Id.* at 1522.

92. *Id.*

93. Komaromy et al., *supra* note 78, at 1305, 1307-08.

94. *Id.* at 1307, 1308 fig.1.

95. *Id.*

96. *See id.* at 1308.

97. *Id.* at 1307-08.

98. *Id.* at 1308.

99. *Id.* at 1306.

100. *Id.* at 1306, 1309.

than non-minority doctors.[101] In this study, 32% of the minority physicians reported having Medicaid caseloads of greater than 40%, as opposed to 10% for non-minority physicians.[102] Almost 60% of non-minority physicians reported having Medicaid caseloads of *less* than 10%, as opposed to 33% of minority physicians.[103]

In a 1995 study, Moy et al. analyzed data from a national survey that had over 15,000 respondents and found that minority physicians were more likely to provide care to racial and ethnic minority patients, poor people, and people who were sicker.[104] Medicaid patients were 2.62 times as likely to receive their care from a minority physician as from a non-minority physician.[105] Patients of minority physicians were much more likely to report being in poor health and having visited an emergency room than patients of non-minority physicians.[106]

More recently, the Association of American Medical Colleges (AAMC) released a report entitled "Minorities in Medical Education: Facts and Figures 2005."[107] This is the thirteenth edition of this critical compilation of data regarding minorities in medical education.[108] In this report, the AAMC documented the findings of its 2004 Medical School Graduation Questionnaire.[109] In this questionnaire, 21% of 2004 graduates reported that they intend to practice in an underserved community.[110] There are noteworthy racial differences: 50% of African Americans, 41% of Native American/Alaska Natives, and 33% of Latino graduates reported an intent to practice in an underserved community, while 18.4% of white graduates reported such intent.[111]

The studies described herein are by no means the only bodies of research documenting the practice patterns of minority physicians. Many other studies have reached the same conclusion.[112] In dismissing the access rationale put forth by the state, the Court in *Bakke* noted that there was insufficient evidence that a race-

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101. Robert C. Davidson & Roberto Montoya, *The Distribution of Services to the Underserved: A Comparison of Minority and Majority Medical Graduates in California*, 146 W. J. MED. 114, 116 (1987).

102. *Id.*

103. *Id.*

104. Moy & Bartman, *supra* note 89, at 1516-17.

105. *Id.* at 1517 tbl. 1.

106. *Id.* at 1517, 1518 tbl. 4.

107. ASS'N OF AM. MED. COLLS., MINORITIES IN MEDICAL EDUCATION: FACTS AND FIGURES 2005, at 5 (2005), *available at* https://services.aamc.org/Publications/showfile.cfm?file=version53.pdf&prd_id=133&prv_id=154&pdf_id=53.

108. *Id.*

109. *Id.* at 7, 9.

110. *Id.* at 9, 49 fig. 31.

111. *Id.*

112. *See generally* Kington et al., *supra* note 15, at 64-77 (documenting studies showing that minority physicians are more likely to serve minority populations, vulnerable patient populations, patients with lower incomes and work in underserved practice locations).

conscious admissions program in question was "likely to have any significant effect on the problem" of improving access to health care in underserved communities.[113] A quarter century later, there is a robust body of research demonstrating that increasing racial and ethnic diversity in the health professions will improve access to health care for underserved, poor, and minority communities.

D. Legal Analysis: Does the Interest in Expanding Access and Eliminating Disparities Rise to the Level of a "Compelling Interest" Justifying the Use of Narrowly Tailored Race-Conscious Admissions and Recruitment Practices?

The concept that increasing racial and ethnic diversity in the health professions is a critical component of an overall strategy to eliminate racial and ethnic disparities in health status and improve access to health care in underserved, minority communities is hardly novel. The famous Flexner Commission report of 1910 concluded that one of the most effective ways to meet the health care needs in African American communities was to increase the number of African American health care providers.[114] This report was released in the context of widespread segregation in America.

Today, while de jure segregation is unlawful, the challenges of eliminating health disparities and expanding access in underserved communities of color remain daunting. The evidence outlined in the preceding section makes the case that increasing racial and ethnic diversity in the health professions is a very effective strategy for addressing the access and disparities challenges. In fact, the Sullivan Commission on Diversity in the Healthcare Workforce, a nonpartisan, blue ribbon panel established by the Kellogg Foundation to study health care workforce diversity issues, released a report in 2004 entitled "Missing Persons: Minorities in the Health Professions."[115] In this report, the Sullivan Commission reached the noteworthy conclusion that the failure of the health professions to keep pace with the changing demographics in America "may be an even greater cause of disparities in health access and health outcomes than the persistent lack of health insurance for tens of millions of Americans."[116]

The need to increase access and eliminate disparities is undoubtedly critical, but the question remains: would the Court conclude that this need is sufficiently "compelling" to justify the use of narrowly tailored race-conscious admissions and recruitment programs? There are three reasons for optimism that a court might

113. Regents of Univ. of Cal. v. Bakke, 438 U.S. 265, 311 (1978).

114. ABRAHAM FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA 180 (1910).

115. SULLIVAN COMM'N REPORT, *supra* note 5, at iv-v. The Sullivan Commission is a nonpartisan, blue ribbon panel established by the Kellogg Foundation to study health care workforce diversity issues. *Id.*

116. *Id.* at 1.

recognize such an interest. First, as the Court in *Grutter* noted, "[c]ontext matters when reviewing race-based governmental action under the Equal Protection Clause."[117] Health care presents a critical and appealing context from which to make the argument for recognition of such an interest. For millions of poor people and minorities in America, the health care system remains separate and unequal. This reality can have dire consequences, and the demographic transformation of America adds a heightened sense of urgency to the situation. It is necessary to implement every feasible intervention that has proven effective in increasing access to health care in underserved, poor, and minority communities. There is a robust evidence base establishing that increasing racial and ethnic diversity in the health professions will increase access to health care for poor, underserved, minority communities, and increase health outcomes.[118] Race-conscious admissions and recruitment programs have a proven track record in increasing the number of minorities in the health professions.[119] This context is critical.

Second, the Court in *Grutter*, in adopting Justice Powell's diversity rationale, ratified a "forward looking" justification for race-conscious decision-making.[120] Rather than limiting race-conscious decision-making to correcting past discrimination, the Court clarified that narrowly tailored race-conscious programs can be employed as a means of capturing the benefits to society of a particular compelling interest now and into the future.[121] To put it differently, race-conscious approaches can be used in certain circumstances to address critical public policy or other societal challenges.

Eliminating racial and ethnic disparities in health status, and expanding access to health care for poor, underserved and minority communities, is a critical public policy and public health challenge. The *Grutter* Court has opened the door to consideration of other compelling interests that are not remedial in nature. The disparities and access challenges are undeniably critical challenges that must be addressed now and into the future.

Third, there is evidence to suggest that race and ethnicity--as opposed to some other race-neutral proxy--is indeed a critical indicator in the determination of likelihood to practice in underserved communities. In examining whether courts would recognize the compelling interest in eliminating racial and ethnic disparities in health status and expanding access to health care for poor, underserved and minority communities, it is important to analyze whether the race-conscious

117. Grutter v. Bollinger, 539 U.S. 306, 327 (2003) (citing Gomillion v. Lightfoot, 364 U.S. 339, 343-44 (1960)).

118. *See supra* notes 82-119 and accompanying text.

119. *See supra* note 10.

120. Helen Norton, *Stepping Through* Grutter's *Open Doors: What the University of Michigan Affirmative Action Cases Mean for Race-Conscious Government Decisionmaking*, 78 TEMP. L. REV. 543, 543 (2005).

121. *Id.* at 4-5.

framework is either "needed or geared to" solving the access and disparities challenges at hand.[122] In other words, it is imperative to study whether there are race-neutral proxies that will accomplish the admittedly laudable goal of increasing access and reducing disparities by increasing racial and ethnic diversity in the health professions.

Critics of the access framework described herein may contend that there are ample race-neutral alternatives that will increase the number of minorities graduating from health professions schools. For instance, a health professions school could simply probe an applicant's demonstrated commitment to practicing in underserved communities. Under this framework, there would be no need to consider an applicant's race or ethnicity.

In dismissing the State's access rationale, the Court in *Bakke* discussed the availability of race-neutral means of measuring physicians' likelihood to practice in underserved communities:

> It may be correct to assume that some [minority doctors] will carry out this intention [to practice in underserved communities], and that it is more likely they will practice in minority communities than the average white doctor . . . . Nevertheless, there are more precise and reliable ways to identify applicants who are genuinely interested in the medical problems of minorities than by race. An applicant of whatever race who has demonstrated his concern for disadvantaged minorities in the past and who declares that practice in such a community is his primary professional goal would be more likely to contribute to the alleviation of the medical shortage [in underserved communities] than one who is chosen entirely on the basis of race and disadvantage. In short, there is no empirical data to demonstrate that one race is more selflessly socially oriented or by contrast that another is more selfishly acquisitive.[123]

There may be race-neutral alternatives that will assist in increasing racial and ethnic diversity in the health professions. However, there is evidence that race in and of itself is a powerful and better indicator and predictor of service to poor, underserved, and minority communities.

A study in 2000 by Rabinowitz et al. focused on the practice patterns of primary care physicians and sought to identify which factors are the best predictors of their likelihood to practice in underserved communities.[124] The research team analyzed which, if any, of the following factors predicted practice in underserved communities:

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122. *See* Regents of Univ. of Cal. v. Bakke, 438 U.S. 265, 310 (1978).

123. *Id.* at 310-11 (quoting Bakke v. Regents of Univ. of Cal., 553 P.2d 1152, 1167 (Cal. 1967)).

124. Howard K. Rabinowitz et al., *The Impact of Multiple Predictors on Generalist Physicians' Care of Underserved Populations*, 90 AM. J. PUB. HEALTH 1225, 1225 (2000).

- Sex;
- Status as underrepresented minority (defined as African American, Latino, Native American, Alaska native);
- Family income when growing up;
- Growing up in an inner-city or rural area;
- National Health Service Corps participation;
- Strong interest in underserved practice prior to medical school; and
- Clinical experience with the underserved while in medical school.[125]

A number of factors correlated with increased likelihood to practice in an underserved community.[126] However, the study team isolated the impact of each factor, and found that race was the greatest determinant of service to underrepresented communities, controlling for all other factors.[127] This upshot of this study is that race and ethnicity matter, and matter more than any other factor in determining whether a physician will practice in an underserved community.[128] Moreover, race and ethnicity matter independently of such other factors as socioeconomic status, prior interest in serving in underserved practice, and clinical experience with the underserved while in school.[129] This study suggests that the Court's above-quoted pronouncement in *Bakke* about the availability of "more precise and reliable ways" than race or ethnicity to attack the access and disparities challenges is in fact incorrect.[130] A nationally respected research team led by the Deputy Director of the National Institutes of Health reviewed the Rabinowitz study and noted:

> The primary intent of this study was not aimed solely at testing whether or not minority physicians provide more care to the underserved. However, the findings with respect to this study question appear quite robust. . . . [M]inority status [has] again emerged as significantly and independently associated with serving a substantial proportion of underserved patients in their caseloads.[131]

Race and ethnicity indeed appear to be the most "precise and reliable" ways of predicting practice in underserved communities, and the Rabinowitz study is not the only report to reach this conclusion.[132] Given the health care emergencies that

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125. *Id.* at 1226 tbl.1 and accompanying text.

126. *Id.* at 1226. The four relevant factors were whether (1) the physician was a member of an underserved minority; (2) had participated in NHSC; (3) had a strong interest in practicing in an underserved area before medical school; and (4) grew up in an underserved area. *Id.*

127. *Id.* at 1226, 1227 tbl.2.

128. *See id.*

129. *See id.*

130. Regents of Univ. of Cal. v. Bakke, 438 U.S. 265, 311 (1978).

131. Kington et al., *supra* note 15, at 75.

132. *E.g.*, Keith et al., *supra* note 90, at 1523; Moy & Bartman, *supra* note 89, at 1517.

exist in so many communities of color as a result of the lack of access to health care, it is imperative for health professions schools to be able to use race-conscious admissions and recruitment practices as a means of increasing racial and ethnic diversity in the health professions. The other indices do not appear to be as effective. Of course, such race-conscious policies and practices would have to comply with the narrow tailoring strictures set forth in *Grutter*.[133] Among other things, this means that race is one of many factors that can be taken into account in a holistic review process.

In terms of court precedents, no court has recognized the compelling interest outlined in this section. As noted earlier, courts have sanctioned non-remedial affirmative action, and have done so in settings other than simply the higher education and K-12 contexts. Police and corrections hiring are two settings in which courts have permitted race conscious decision-making.[134] *Wittmer v. Peters* is the seminal case establishing that in the corrections hiring context, non-remedial race-conscious hiring policies are permissible as long as the government can demonstrate that such policies are necessary to accomplish important law enforcement objectives.[135] Corrections experts agree that it can be very difficult to perform corrections functions effectively if the inmate population is predominantly one race or ethnicity, and the corrections officers are predominantly of a different race or ethnicity.[136]

In the police context, courts have upheld race-conscious hiring and promotions practices, noting that, "effective crime prevention and solution depend heavily on the public support and cooperation which result only from public respect and confidence in the police. In short, the focus is not on the superior performance of minority officers, but on the public's perception of law enforcement officials and institutions."[137] It is extremely difficult, if not impossible, to implement effective community policing strategies if the police force does not resemble the communities being served, because it is more difficult to earn the public trust and confidence necessary to preventing crime and building community support. Also, it can be extremely difficult to conduct effective undercover operations if a police force does not include officers of the same race or ethnicity as the community where the operations are being carried out. Citing

133. Grutter v. Bollinger, 539 U.S. 265, 339-41 (2003).

134. Wittmer v. Peters, 87 F.3d 916, 919 (7th Cir. 1996) (listing cases in law enforcement and corrections that have upheld considerations of race).

135. *Id.* at 919-20.

136. *Id.* at 920.

137. Detroit Police Officers' Ass'n v. Young, 608 F.2d 671, 696 (6th Cir. 1979) ("The argument that police need more minority officers is not simply that blacks communicate better with blacks or that a police department should cater to the public's desires. Rather, it is that effective crime prevention and solution depend heavily on the public support and cooperation which result only from public respect and confidence in the police. In short, the focus is not on the superior performance of minority officers, but on the public's perception of law enforcement officials and institutions.").

operational need, courts have repeatedly given latitude to police and corrections departments to implement narrowly tailored race-conscious hiring and promotion practices.[138]

The health care setting is distinguishable from the police and corrections settings in the sense that it is at least theoretically possible to reduce health disparities and increase access to health care for vulnerable communities without adopting race-conscious admissions policies designed to increase racial and ethnic diversity in the health professions. On the other hand, in the police setting, community policing simply does not work as effectively when a department does not reflect the community it serves.[139] The case outlined above for judicial recognition of a compelling interest in reducing disparities and increasing access to health care for underserved, poor, minority communities is not premised on the "operational necessity" rationale set forth in the police and corrections settings. Such arguments in all likelihood would not withstand scrutiny in the health context.

Overall, it is time for health professions schools to invest in affirmative action insurance policies by building the case for judicial recognition of the compelling interest in eliminating racial and ethnic disparities in health status and increasing access to health care for poor, underserved, minority communities. Ample empirical evidence exists to support judicial recognition of such an interest, including evidence that race and ethnicity are the best indicators of a health care provider's likelihood of practicing in a poor, underserved, minority community.[140] Time may be of the essence. The need to construct alternative defenses of race-conscious admissions and recruitment practices in higher education is greater in light of the fragile majority in *Grutter* and the retirement of Justice O'Connor, who was the architect of the *Grutter* framework and the decisive vote in the case.[141]

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138. *See, e.g.*, Wittmer v. Peters, 87 F.3d 916, 919 (7th Cir. 1996) (citing Barhold v. Rodriguez, 863 F.2d 233, 238 (2d Cir. 1988)); Talbert v. City of Richmond, 648 F.2d 925, 931-32 (4th Cir. 1981); Detroit Police Officers' Ass'n. v. Young, 608 F.2d 671, 695-96 (6th Cir. 1979); Minnick v. California Dep't of Corrections, 95 Cal. App. 3d 506, 157 (1979).

139. *See Young*, 608 F.2d at 696.

140. *See, e.g.*, Keith et al., *supra* note 90, at 1520; Moy & Bartman, *supra* note 89, at 1517.

141. Writing for the majority, Justice O'Connor stated, "[w]e find that the Law School's admissions program bears the hallmarks of a narrowly tailored plan. As Justice Powell made clear in *Bakke*, truly individualized consideration demands that race be used in a flexible, nonmechanical way." Grutter v. Bollinger, 539 U.S. 265, 334 (2003). "We also find that, like the Harvard plan Justice Powell referenced in *Bakke*, the Law School's race-conscious admissions program adequately ensures that all factors that may contribute to student body diversity are meaningfully considered alongside race in admissions decisions." *Id.* at 337. "Because the Law School considers 'all pertinent elements of diversity,' it can (and does) select nonminority applications who have greater potential to enhance student body diversity over underrepresented minority applicants." *Id.* at 341.

E. Does the Access Framework Have Application in the Legal Context?

The health professions are the most effective contexts to put forth this access claim, because the evidence base is strongest. It is interesting to examine whether a similar case could be made in other professions. While the empirical basis is not as robust as in the health professions context, there is some evidence that lawyers of color are also more likely to provide service to underserved communities than their white counterparts.

The findings of a 1997-98 survey examining the post-graduation performance and careers of minority alumni of the University of Michigan Law School found that minority alumni as a group provided much more service to minority clients than their white counterparts did.[142] In addition, minority alumni who entered private practice tended to do more pro bono work, serve on more community boards, and exercise more community leadership through political activity than white graduates.[143]

This pattern of service has also been found among Asian and Pacific Islander American alumni from the UCLA School of Law. This school, which has been one of the leaders in promoting racial diversity in the legal field, implemented an affirmative action program in 1967 to give disadvantaged students of color a legal education subsidized by the state.[144] A 1988 survey of Asian and Pacific Islander American law school alumni found that UCLA's Legal Education Opportunity Program (LEOP)/diversity alumni "contributed seven times more pro bono hours in the minority communities, and almost four times (3.7) the amount of time in minority civil or business organizations than their regular admit counterparts."[145] In addition, 46.7% of regular practice clients of the LEOP/diversity admittees were from ethnic or minority groups, compared to 25.2% of clients of regular Asian and Pacific Islander American admittees.[146] LEOP/diversity admittees also served a much higher proportion (2.7 times) of low-income/working class clients in regular practice than regular admittees did.[147] The findings suggest that excluding Asian and Pacific Islander Americans from affirmative action programs might have an adverse effect on the number of Asian and Pacific Islander American lawyers working with underserved communities.[148]

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142. Richard O. Lempert et al., *Michigan's Minority Graduates in Practice: The River Runs Through Law School*, 25 LAW & SOC. INQUIRY 395, 397 (2000).

143. *Id.*

144. Albert Y. Muratsuchi, *Race, Class, and UCLA School of Law Admissions, 1967-1999*, 16 CHICANO-LATINO L. REV. 90, 90 (1995).

145. *Id.* at 130, 132-33 (citing Memorandum from the Asian Concerns Committee to the Faculty of the UCLA School of Law, Results of the UCLA Asian Alumni Survey (May 9, 1988)).

146. *Id.* at 140 app.II.

147. *Id.*

148. *See* William C. Kidder, *Situating Asian Pacific Americans in the Law School Affirmative Action Debate: Empirical Facts About Thernstrom's Rhetorical Acts*, 7 ASIAN L.J. 29, 55 (2000)

Research conducted by the Task Force on Minorities in Legal Profession of the New Mexico State Bar combined with census data shows that minority graduates from the University of New Mexico School of Law tend to represent minority and underserved communities.[149] The New Mexico Bar has even stated that the law school's race-sensitive admissions practices and racial diversity are "indispensable to a racially diverse state bar that can serve the legal needs of all citizens."[150]

The results of these studies underscore the significant impact that law school diversity programs can have in improving access to justice for—and meeting the legal needs of—underserved communities. However, the findings are limited because they only examine several schools and certain groups of graduates. Additional research needs to be conducted to build a firm base of empirical knowledge that courts will recognize as being even more compelling. Therefore, law schools should invest in the research necessary to establish whether it is indeed accurate that lawyers of color are more likely to serve communities of color, and more likely to serve poor, underserved communities. It would be important to investigate the precise role that race and ethnicity—as compared with other race-neutral indicators—play in explaining the evidence.

III. TURNING THEORY INTO REALITY: GUIDANCE ON HOW TO MOVE THE "ACCESS" RATIONALE FORWARD

Proponents of affirmative action in higher education owe a major debt of gratitude to Lee Bollinger, the former President of the University of Michigan, and others at the University of Michigan who made a large investment in building the case for diversity. The extensive record developed in the lower courts was a critical component of the successful defense of race-conscious admissions programs.[151] *Grutter* is replete with references to the record developed in the lower court proceedings. The diversity rationale is potentially on thinner legal ice in light of Justice O'Connor's retirement, although nobody can state with any degree of certainty exactly how thin the ice has become. As a result, it is important

(suggesting that excluding Asian Pacific Americans from affirmative action practices will decrease the amount of lawyers working with underserved communities).

149. Brief for the New Mexico Hispanic Bar Association et al. as Amici Curiae Supporting Respondents, Grutter v. Bollinger, 539 U.S. 206 (2003) (No. 02-241), *reprinted in* 14 LA RAZA L.J. 51, 64-65 (2003) (noting that the data was a compilation of census data with State Bar Report).

150. Brief for the New Mexico Hispanic Bar Association et al. as Amici Curiae Supporting Respondents, Grutter v. Bollinger, 539 U.S. 306 (2003) (No. 02-241) *in* 321 LANDMARK BRIEFS, *supra* note 61, pt.3, at 710.

151. *See, e.g.*, *supra* note 61 and accompanying text.

for health professions schools to build the case for judicial recognition of the access rationale.

Schools interested in continuing the use of race-conscious admissions practices under the "access" rationale should consider the following strategies.

A. Research Agenda

Despite the robust body of research outlined above regarding practice patterns of minority health care providers, a substantial research agenda remains. Although the evidence regarding practice patterns is similar across health professions, the research is most plentiful in the physician context. It is important for all health professions schools to invest in research around this question of practice patterns, so that one health profession is not in the position of having to rely primarily on data from another health profession to make the case for judicial recognition of the access rationale. The results of the research have been remarkably consistent across health professions.[152] It is important to have a sufficient quantity of methodologically sound studies in each profession, so that schools will have the evidence base to proceed with race-conscious admissions policies designed to further the compelling interest in reducing disparities and increasing access to health care for poor, underserved, minority communities.

B. Mission Statement Review

Health professions schools interested in implementing race-conscious admissions and recruitment programs should re-examine their mission statements to determine how they have defined their institutional mission. Programs, policies, and practices at any institution should flow from the institution's mission statement, and it may be useful for health professions schools to conduct a self-assessment and reflect upon the importance of both diversity and service to underserved communities.

A more explicit commitment in a mission statement to obtaining the educational benefits that flow from a diverse student body, and to producing a

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152. *See, e.g.*, COMM. ON INST. DIVERSITY, *supra* note 68, at 5 ("r]acial and ethnic minority dentists . . . are also more likely than their white peers to practice in racial and ethnic minority communities"); Richard G. Weaver et al., *Annual ADEA Survey of Dental School Seniors: 2003 Graduating Class*, 68 J. DENTAL EDUC. 1004, 1006, 1006 tbl.8 (2004) (reporting that almost 70% of African American dental student respondents indicated that service to one's own race was somewhat or highly important in their career choice, compared to 14% of white students); Castellano B. Turner & Barbara Formaniak Turner, *Who Treats Minorities?*, 2 CULTURAL DIVERSITY & MENTAL HEALTH 175, 179 (1996) ("[e]thnic minority providers . . . were significantly more likely than non-Latino White providers . . . to see ethnic minority clients"); NAT'L ADVISORY COUNCIL ON NURSE EDUC.& PRACTICE, HEALTH RES. & SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., A NATIONAL AGENDA FOR NURSING WORKFORCE: RACIAL/ETHNIC DIVERSITY 14 (2000) ("minority nurses are significant . . . leaders in the development of models of care that address the unique needs of racial/ethnic minority populations.").

well-trained health care professional committed to addressing the health care needs of the underserved, can form the basis of policies and practices, such as race-conscious admissions and recruitment policies, that will maximize the chances for success in achieving these goals.

C. Revamping Admissions and Recruitment Policies

Reviewing mission statements and incorporating the elimination of disparities and improving access to underserved communities should invariably lead to the development of revised admission policies and practices. If a health professions school is contemplating race-conscious admissions policies using the access rationale, it is imperative to set forth the rationale in a written admissions policy.

It is equally important to have the evidence base adequately developed and readily at hand in the event of a legal challenge. It is important to remember a basic adage of policy development: good facts make good law, and bad facts make bad law. Conclusory statements about the need to increase access to health care for underserved populations—and eliminate racial and ethnic disparities—without more, will not justify the use of a race-conscious admissions policy or practice. The evidence base connecting race-conscious admissions policies and service to underserved communities exists, although it can certainly be buttressed further. Health professions schools must become conversant with this evidence base so that they are in the best position to defend against a constitutional challenge to this program.

CONCLUSION

In the past two years, two seminal reports have been issued addressing health care workforce diversity—one by the Institute of Medicine (IOM) and one by the Sullivan Commission. The names of each report are instructive. The IOM Report is entitled *In the Nation's Compelling Interest: Ensuring Diversity in the Healthcare Workforce.*[153] The Sullivan Commission Report is entitled *Missing Persons: Minorities in the Health Professions.*[154] The blue ribbon panels that reviewed the health care landscape for vulnerable populations both concluded that it is indeed in the nation's compelling interest to develop a comprehensive strategy to increase the racial and ethnic diversity of the health care workforce. This is a life or death matter in so many communities across America.

These reports were designed to be a wakeup call for policymakers, educators, communities, and other stakeholders to develop a comprehensive plan to increase racial and ethnic diversity in the health professions. This article reflects an effort to build upon the challenges outlined in these calls to action and construct an

153. COMM. ON INST. DIVERSITY, *supra* note 68.

154. SULLIVAN COMM'N REPORT, *supra* note 5.

additional legal framework to supplement the diversity rationale for race-conscious admissions and recruitment policies. Too many poor people and people of color simply do not have access to health care, and are suffering unnecessarily or in some cases, dying prematurely and tragically. As a nation, we must develop an aggressive strategy to expand access to health care for vulnerable people that rests on as many legal pillars as possible.

This article has set forth the evidence base linking a race-conscious admissions program to progress in increasing access to health care for poor, underserved, and minority communities and progress in eliminating racial and ethnic disparities in health status. It is time to put this evidence base into action and construct narrowly tailored race-conscious admissions programs on this framework. This access rationale for race-conscious decision-making in health professions schools has its roots in the *Bakke* decision itself. While this rationale may be untested in the courts, and would currently supplement the judicially sanctioned diversity rationale set forth in *Grutter*, the future status of the *Grutter* framework may hinge on the recent transition in the Supreme Court. As a result, while the insurance policy may not be necessary in the immediate future, it is important nonetheless to purchase this insurance policy for race-conscious admissions in the health professions.