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Given the 2023 Supreme Court Decision on Affirmative Action Changes, should Race and Ethnicity be used as a Criterion for Admission to Medical School

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Essay

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Abstract

The guarantee of equal protection cannot mean one thing when applied to one individual and something else when applied to a person of another color. If both are not accorded the same protection, then it is not equal." **Justice Powell**

Keywords: Affirmative Action Changes; Decision

Abbreviations: AI: American Indians; AN: Alaska Natives; GPA: Grade Point Averages; MCAT: Medical College Admissions Test.

Essay

Description of the Problem

Race-based affirmative action programs in higher education is no longer a requirement by a 6-3 Supreme Court decision. They went on to conclude that affirmative action admission decisions violate the Equal Protection Clause of the 14th Amendment. However, they did not address the health outcomes of such a decision. The Commonwealth Fund, 1994 National Comparative Survey of Minority Health Care, concluded that African Americans and Hispanic Americans sought care from physicians of their race because of personal preference. Similar studies showed evidence that African American and Hispanic patients are more likely to seek care from clinicians of their race because of personal preference or language, and not only because of location. Yet, minorities are seriously under-represented in health professions, and the situation is not improving [1]. African Americans, Hispanic Americans, American Indians and Alaska Natives (AI/ANs) as a group comprise nearly 25% of the US population. These populations account for less than 9% of nurses, 6% of physicians, and only 5% of dentists. Thus, as minority populations continue to grow, the demand for minority physicians is likely to increase. Keeping up with this need requires medical school admissions criteria, policies and physician workforce planning to include detailed plans to increase the number of underrepresented minority physicians [2]. However, it is illegal for U.S. Medical Schools to use race or ethnicity as selection criteria. This issue was argued and confirmed in the U.S. Supreme Court.

Public Health Implications

The existence of ethnic and racial healthcare disparities needs to be acknowledged, and this acknowledgment carries the responsibility of action to work for the elimination of disparities. African Americans and Hispanic physicians account for only 4% and 5 %, respectively, of all U.S. physicians. According to a national survey, they care for 25% of African American patients and 23% of Hispanic American patients. This translates into the remaining 75-80% of the combined population being seen by physicians of a different race. This statement alone does not illicit a

double take if you are not a member of this population or if you are not aware of the health disparities among these groups. However, these populations are twice as likely to die from chronic diseases such as cardiovascular disorders, diabetes, obesity, and cancer just to name a few. This data suggest that perhaps if there were more African American and Hispanic physicians to care for African Americans and Hispanic American patients this data might look different. The implication based on these findings suggests that if African American and Hispanic patients prefer physicians who are of the same race, then perhaps they would seek care earlier versus seeking care when their disease has seriously progressed. This also strongly suggests that increasing the number of minority applicants to medical school may be a solution to minority healthcare disparities and improved medical care to underserved populations.

Relevant Policy Actions

As stated earlier, it is illegal for U.S. Medical Schools to use race or ethnicity as selection criteria. This issue was argued and confirmed in the U.S. Supreme Court in 2023 as well as argued and the Supreme Court decision confirmed in the state of California, U.S. Supreme Court Regents of Univ. of California v. Bakke, 438 U.S. 265 [3]. Regents of the University of California v. Bakke No. 7811 argued October 12, 1977, and decided June 28, 1978 438 U.S. 265**.** But it is worth mentioning that in this case it was argued that UCLA admission process excluded an applicant based on his race (Caucasian) to be a violation of the Equal Protection Clause of the Fourteenth Amendment, a provision of the California Constitution, and § 601 of Title VI of the Civil Rights Act of 1964, which provides, *inter alia,* that no person shall on the ground of race or color be excluded from participating in any program receiving federal financial assistance. This is noted because this can be an alternative or reverse racism argument.

However, there is a section of the ACA Senate bill: "Section 2046 (b)(3), which directs the secretary of health and human services to award federal grants worth billions of dollars to educational institutions that train medical-service providers. In addition, there is a "priority" for federal dollars to be given only to those institutions offering 'preferential' admissions to underrepresented minorities (according to race, national origin, sex, sexual orientation and religion). Thus, schools will be unable to compete for essential federal funding unless they adopt admission policies that intentionally and deliberately discriminate. Some people have inserted in the Washington Times article that the restrictions in the senate bill have huge moral deficits that are antagonistic to the recent Supreme Court ruling. Even in a more recent case ruling where the high court did allow limited racial preferences, Grutter v. Bollinger in 2003, the court went to great lengths to note that "racial classifications, however compelling their goals, are potentially so dangerous that they may be employed no more broadly than the interest demands".

Lastly, this is a complex conundrum with many sides to argue. However, from a public health perspective two important aims are clear: (1) to increase healthcare services and (2) to improve access to care for underserved populations. This can be translated into characteristics beyond race and skin color and consider the term underserved population. Moreover, it posits the likelihood that African Americans, Hispanics, and other minority groups will more than likely fall into the category of an underserved population. As a result, this creates an increase in the number of underserved individuals/groups entering medical school and physicians dedicated to providing medical services to underserved populations.

Background

This brief would be negligent if it did not review American History concerning race relations. Race relations are important because they directly drives policies and the living conditions of underserved populations. When the history of America concerning race relations is examined starting at the beginning of slavery, one can theorize that racism is the root cause of racial and ethnic health care disparities. Since the Civil War, the policies of the United States have attempted to erase the evidence of such oppression and inhumane practices. But nonetheless, policies that support inequities in health care, education, and housing to name a few, continue to live and thrive in the neighborhoods of the minorities and the poor, in other words, the underserved population.

In 1967 during the midst of the Civil Rights Movement, Americans witnessed horrific examples of racially based behaviors across 23 major cities; as such President Johnson appointed a special commission team to examine the problems [4]. The report of the National Advisory Commission on Civil Disorder [5], examined the root causes of what The New York Times characterized as the "violent racial crisis in America today." The disparity" in meeting the health care needs of the non-white population" was cited by the Commission as one factor that is at the root of the racial crisis. More importantly, this report highlighted health disparities by stating residents of the racial "ghettos" are significantly less healthy than most other Americans. It was also highlighted that African Americans and Hispanics suffered from higher mortality rates, higher incidence of major diseases, and lower availability and utilization of medical services. Advocacies for the civil rights movement voiced the need for actions to reverse what the committee described as the "deepening racial division". Fast forward to 2015, there continue to be policies that support racial division

and disparity concerning health care access, and educational and social programs which negatively impact underserved populations. Moreover, these disparities are also maintained by continued policies that perpetuate poverty, poor health care, and underfunded education opportunities.

Statistics

In 1994, the Commonwealth Fund completed a study that focused on "underserved minorities". The study surveyed 3,789 adults, 1,114 whites, 1,048 African Americans, 1,001 Hispanics and 632 Asian-Americans. Listed below are a few of the findings that are relevant to this paper.

- 18 percent of minorities said they have difficulty obtaining specialty care, compared to 8 percent of whites; these minorities also reported that they would prefer culturally sensitive providers or providers of the same race.
- 21 percent of minority adults have problems with language differences in receiving care, with about one-quarter of those who do not speak English as a first language needing an interpreter when seeking health care services
- 60 percent of whites said they are satisfied with their health care, compared to 46 percent r if they were of a different race; and these findings strongly suggest that more minority medical providers are needed and for that to happen there needs to be a strong push to recruit prospective students from these groups. The American Medical Association (50-1-95) released a policy addressing similar disparities. This policy also suggested that more minority physicians are needed and therefore this paper asserts that a change to the criteria for admission into medical schools is warranted which will take into consideration racially related political, educational, and economic barriers to higher education for minorities.

Analysis

The data presented above suggests that the existence of racial and ethnic disparities is just as salient today as they were in the past. As we approach the beginning of 2024, it is important to note the continued existence of racial disparities. There are continuous reports of poverty, school closings in the poorest of neighborhoods, racial profiling, and budget cuts for social programs that assist disadvantaged and underserved populations. We must acknowledge advances in medicine and healthcare access within the last two decades for those with insurance that have resulted in a healthier society. However, because of the chronicity of racial disparities, and race-based trauma, chronic illnesses are still just as prevalent within the underserved populations, specifically in the African American and Hispanic communities. As a public health and mental health advocate, this fact is particularly troublesome given that most of the healthcare problems of the past are even worse in our underserved populations. The reader only must look at the nightly news, communities, schools, and research studies and understand what the healthcare reform debate of 2010 was trying to resolve and must continue to strive to meet the goals of the World Health Organization. In the 2020 report, the top 10 causes of death accounted for 55% of the 55.4 million deaths worldwide. The lack of access to health care, insufficient minority medical providers, and poor quality of care remain rampant and push the statistics for this population 2-3 times higher than higher income populations. However, as stated earlier it is unlawful to set admission criteria to professional schools based on race or ethnicity, but no law prohibits admission criteria based on disadvantaged or underserved population status. So, we must develop a pipeline program that will cultivate students from underserved communities into medical school programs as a way to balance and address the healthcare needs of underserved populations.

Recommendations

To increase the number of physicians that will treat underserved populations we must consider making changes to the criterion for admission to medical school. In addition, research data suggests that minority or underserved populations prefer physicians within their culture. So, a program that will recruit individuals from underserved areas and train them to be physicians might improve access to care in these areas. This recommendation section will discuss a pipeline proposal. This proposal is not to promote handouts but a hand-up solution to a problem that requires a multifaceted solution. This can be done by targeting underserved students from underserved groups versus using race or ethnicity directly, which is prohibited. This paper proposes that state-affiliated medical schools would have two admissions programs [6-9]. Program A would use regular admissions protocols and Program B would be a special admissions program to recruit students from underserved populations. Under the Program A, a candidate whose overall undergraduate grade point averages (GPA) does not meet the cut-off they should be rejected. Undergraduates who's GPA does meet the cut-off should be given an interview and based on applicant's interview rating, overall grade point average, science courses grade point average, Medical College Admissions Test (MCAT) scores, letters of recommendation, extracurricular activities, and other biographical data, should be considered. Program B would target members of underserved groups and applicants identified as "economically and/or educationally disadvantaged" versus using the criteria of applicants who identify as a member of a "minority group" based on skin color (blacks, Latinos, Asians, American Indians, Appalachian

Whites). Program B candidates can also be considered disadvantaged even if they classify themselves as "white", thus eliminating racial preference and practicing within the scope of the law. This process would decrease or eliminate the alternative arguments of exclusion due to race. Program B candidates would also be required to attend a two-year preparatory program that will prepare them for the rigors of medical school which would start after completing two years of undergraduate courses. This program would be a pipeline program into medical school.

Limitations

Some reports suggest that there are over three million people who die of diabetes each year and seventy million people are diagnosed with hypertension which costs the U.S. **$46 billion each year**. This total includes the cost of health care services, medications to treat high blood pressure, and missed days of work. These facts are staggering and when you look at the percentage of minorities who suffer from these disorders alone and highlight that there are significant disparities within racial groups [10-13]. So, why do we have disparities that negatively impact African Americans and other minority populations? The simple answer is historical and structural racism that perpetuates intergenerational poverty, chronic race-based bias, and stress to include an undereducated population. In turn, poverty is deemed the most important limitation. Poverty prevents minorities from completing high school, college as well as professional schools. Poverty also perpetuates mental illness, criminal behavior, poor preventative care, and poor medical care.

Another important limitation would be collaborating with the executive, judicial, and legislative branches of the U.S. Government. Congress would have to be committed and dedicated to correcting racial and ethnic tragedies of the past. Similarly, public opinion must be shifted from seeing underserved populations as those who just want "handouts" to a population who deserves a hand-up toward a world of opportunities and potential. A pipeline program could be that hand-up.

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