

# Trust, Patient Well-Being and Affirmative Action in Medical School Admissions

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## Abstract

This article reviews the current legal arguments for and against affirmative action in medical education. It concludes that many of the traditional legal defenses for race-based admissions are imperiled or defunct. The author suggests that the best and probably most viable justification for affirmative action policies is the one that recognizes that racial diversity in the medical profession is important because it provides the physicians with whom minority patients can feel safe and comfortable. Trust is a central component of the doctor-patient relationship and is the prerequisite, in many cases, to the individual physician's ability to practice good medicine. Unfortunately, minorities' historical and current experience with the medical profession and health delivery system frequently breeds suspicion rather than faith. As a result, society and the medical profession have a compelling interest and duty to produce physicians who can inspire trust in patients. In the short-to-medium term, race-conscious admissions policies may be necessary to fulfill this duty. **Key Words:** Trust, affirmative action, racial prejudice, medical education.

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JORDAN COHEN, President of the Association of American Medical Colleges (AAMC) (1), recently predicted increased attempts to overthrow affirmative action programs nationwide and encouraged those associated with medical education to "beat back attacks on affirmative action in higher education wherever they surface." Cohen's concern is well founded. A growing number of federal court decisions have undercut the legal position of educational institutions that wish to use race-based criteria to shape their student bodies. Advocacy groups have fashioned a well-organized strategy to attack affirmative action legally and politically on a national scale. Three universities and their law schools have now been sued by non-minority individuals who claim that they have been wronged by affirmative action policies. Voters in two states, California and

Washington, have banned the use of race in university and professional schools' admissions policies through popular referendums. Numerous state legislatures have considered bans on affirmative action in the face of what appears to be declining public support for the practice (2–5). Opponents of affirmative action have yet to make medical education the focus of their attention. But a direct challenge to medical schools' long commitment to affirmative action policies seems to be on the horizon. Indeed, nationally syndicated columnist Jeffrey Jacoby has attacked the practice (6), claiming that "The cost of medical affirmative action isn't theoretical. It is paid in human suffering—sometimes in human lives." Thomas Sowell has condemned affirmative action in medical education as a "self-justifying fraud" that endangers patients (7).

The fervor and increasing prevalence of such charges confirm the urgency of Jordan Cohen's call for a reinvigorated defense of affirmative action programs in medicine. There are a number of ways in which one might defend affirmative action in medical schools, as well as in other con-

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texts. Those arguments, to the extent that they are honest and effective, should be nurtured. But many traditionally sound “legal” justifications for the practice are either disappearing, or are under attack. As a result, the strongest legal defense of affirmative action is likely to be one that refurbishes and renews the claim that diversity is central to the goal of medical education because it is central to the goal of medicine—better patient care. Unfortunately, as Christopher Edley, former special counsel to President Clinton (8), has noted, supporters of affirmative action in the past have been too quick to rely on diversity arguments with little or no explanation. This oversight has limited its utility as a legal and political justification. Some courts, too, have significantly weakened the constitutional viability of the diversity justification. Despite these comments, a review of existing case law suggests that a reconstruction of the diversity concept and its role in medical education is more likely to survive constitutional scrutiny than other strategies (9).

### The Law

Current constitutional jurisprudence and escalating private litigation are endangering affirmative action policies nationwide. In 1994, in *Podberesky v. Kirwan*, the 4th Circuit Court of Appeals held that the University of Maryland’s race-based scholarship program was constitutionally impermissible (10). The 1996 *Hopwood v. Texas* 5th Circuit Court ruling made it virtually impossible for educational institutions in Texas, Louisiana and Mississippi to take race explicitly into account in their admissions decisions (11). In late 1998, the First Circuit Court in *Wessman v. Gittens* prohibited the prestigious Boston Latin School’s affirmative action policy, a practice in place in part because the institution had once practiced racially discriminatory policies (12).

Legal challenges to affirmative action policies are primarily based on the “equal protection” clause of the 14th Amendment of the U.S. Constitution. The 14th Amendment stipulates that “No state shall . . . deny to any person within its jurisdiction the equal protection of the law.” The equal protection clause applies not only to state laws, but also to the policies and actions of state agents and state institutions. Actions involving classification, differentiation, or discrimination based on race must meet an especially high, court-designed test—the “strict scrutiny test.” Under the strict scrutiny test, the challenged state classification is presumed to be unconstitutional and invalid unless the state entity can show that

the racial classification or action is necessary to further a “compelling state interest.” In addition, the state must show that the state action in question is “narrowly tailored” to further the compelling state interest; that is, the state must consider: (1) the efficacy of alternative remedies; (2) the flexibility and duration of the policy; (3) the relationship between the program’s numerical goals and the percentage of minorities in the relevant population; and (4) the impact of the program on the rights of third parties (13).

The courts have adopted this high standard in view of the history of legal discrimination against African Americans, and use it to strike down nearly any state action that discriminates “against” minorities (14). Legal scholars and judges agree that the strict scrutiny test is appropriate for state actions that have the effect or intent of “harming” minorities. Many, however, argue that a more permissive standard should be applied to state action that is intended to “benefit” minorities (15, 16). For example, if courts used the “intermediate-level-of-scrutiny test” to judge the constitutional validity of state actions intended to benefit minorities, programs like affirmative action would be more likely to pass constitutional scrutiny. Supreme Court rulings on the issue remained inconclusive until *Richmond v. Croson* (1989) and *Adarand Constructors, Inc. v. Peña* (1995), which held that racial classifications used for affirmative action purposes must meet the same strict scrutiny test that is applied to other racial classifications (17, 18). It is possible that future federal judges and supreme court justices will reevaluate the standard of review that should be applied to state action intended to benefit minorities. But for now, medical schools and other state institutions must pass the strict scrutiny test when attempting to aid minorities with race-specific actions (19, 20).

### The Law of Bakke

Given the current state of affirmative action jurisprudence, what must a medical school or legislature do to justify affirmative action practices and policies designed to increase African American and other minority enrollment in medical schools? There are some fairly clear guidelines. Medical schools cannot have explicit quotas or set-asides based on race. For example, some schools may have a “rolling admissions” policy that sets aside a number of reserved seats for particular racial groups, perhaps linked to the percentage of the minority in the state, region or nation. This is the kind of practice that Regents

of *University of California v. Bakke* (1978) rendered constitutionally unacceptable (21), even though it might be defended on the grounds of policy or justice. Neither can a medical school have dual admissions committees or attempt to attract minority matriculants with race-based scholarship programs (10, 11).

Although these forms of affirmative action are almost certainly prohibited, Justice Lewis Powell explained in *Bakke* that race could be permissibly used as one “plus-factor,” among others, in admissions considerations. For example, admissions committees may weigh considerations such as geographic origin, maturity, civic contribution, leadership potential, relevant work experience, as well as grades and standardized test scores, in order to achieve intellectual diversity. According to *Bakke*, race may also be considered one of these plus-factors as long as the race of the applicant does not prove to be the “decisive” or determinative factor in the decision to admit the student (21). While this principle emanated in the *Bakke* case is under attack by some, it has been widely accepted for two decades. This policy gives admissions committees some flexibility in their admissions deliberations to increase cultural and intellectual diversity in their student bodies.

But *Bakke* does not give admissions committees a free hand when considering the race of those who will matriculate at their institutions. If race as a plus-factor is determinative in individual cases, those cases must face the strict scrutiny test if challenged by a disgruntled non-minority applicant. The Center for Individual Rights, an activist anti-affirmative action group, has produced and distributed a detailed handbook to aid applicants who feel they have been treated unjustly (22). The handbook encourages prospective students to be “skeptical” of claims that race is used only as a plus-factor, and identifies what it deems “suspect” admissions practices. In addition, it provides detailed guidance on how non-minority applicants can discover and demonstrate whether an institution is using race as a determining or decisive factor in its admissions decisions (23). Individuals, through the various states’ freedom of information acts, can gain access to a wide range of information, including school policies, application files, minutes of meetings, worksheets and correspondence (24, 25). The applicant pool’s racial make-up, GPAs, standardized test scores, residency and other variables can be evaluated using common statistical techniques, in an attempt to determine whether race played a decisive role in the institution’s decision to admit students.

If an individual challenging a medical school’s admissions practices can demonstrate, through statistical summary or otherwise, that race has played a determining role in decisions to admit students, then the burden shifts to the institution to defend its admissions practices. If the medical school can prove that the non-minority applicant would not have been admitted, even in the absence of race-conscious practices, the challenge will fail. However, it may sometimes be difficult for institutions to make such showings, given the difficulty of proving a negative (i.e., that the applicant would not have been admitted) and the excellent qualifications of the students likely to be chosen as lead plaintiffs in anti-affirmative action cases. In order to justify its practices, the medical school would then have to defend its admissions practices according to the strict scrutiny test. By this test, an admissions practice that is shown to use race as a determining factor will be presumed to be unconstitutional unless the medical school demonstrates (1) that the policy or practice is motivated by a “compelling state interest” and (2) that it is narrowly tailored to achieve that state interest.

### Discrimination

Courts have agreed that the intent to remedy the effects of discrimination represents a “compelling state interest” under the 14th Amendment. However, medical schools will likely have difficulty defending race-based policies on these grounds. The Supreme Court has definitively declared that the intent to remedy the effects of general “societal” discrimination, racism and prejudice is “not” a compelling state interest. Instead, to justify a race-based remedy, policy makers must precisely identify specific acts of past or current discrimination by state institutions or actors (26, 27). This test was applied exactly in *Hopwood* (28), which held that racially based programs at a state professional school could only be justified if there was evidence of the effects of discrimination “by that institution.” If the *Hopwood* approach prevails, it will be virtually impossible for medical schools to justify affirmative action practices based on the effects of past discrimination. Most medical schools have long-standing commitments to affirmative action and have long since abandoned explicitly discriminatory policies (29, 30).

It is possible, however, that other courts will not accept the *Hopwood* formulation and may allow medical schools to demonstrate that their policies are intended to remedy the continuing effects of dis-

crimination that have occurred throughout other units in the relevant state's public education system. State institutions of higher learning are linked directly to the state's primary and secondary educational system. Consequently, it seems reasonable to allow medical schools, professional schools and other institutions of higher learning to remedy the continuing effects of past discrimination in K-12 years of the same school system (28).

Even this approach will pose difficulties to medical schools defending challenged affirmative action practices. Medical schools established policies years ago under the assumption that the use of race as a "plus-factor" was constitutionally permissible in order to create a more diverse educational environment (21). These schools did not base their affirmative action programs specifically on an attempt to remedy past discrimination, even though that was almost certainly an additional goal of these programs. Consequently, medical schools and policy makers probably never collected specific evidence of the effect of racial discrimination or attempted to explicitly link their remedial policies to the harms generated by racial discrimination. That evidence will probably be difficult to collect after the fact (31). It may be similarly difficult to provide courts with evidence of discrimination against the minority students currently applying for admission to medical schools. Most of the students now entering medical school were educated in a public school system substantially cleansed of "overt," state-mandated discrimination (32). Although discrimination in a number of guises continues to harm minorities in society, and perhaps in the educational system, such discrimination may not be easily demonstrable or linked to official state policy. Moreover, such evidence, if collected retrospectively in order to justify medical school affirmative action policy, may not be accepted by the courts. According to Christopher Edley, the "issue of post hoc evidence is critical" because many practices and programs were adopted without detailed evidential findings and it would be politically impossible to re-legislate now (8).

Racism and discrimination continue at the societal and institutional levels and may justify remedial action. However, law and morality are not always consonant. The type of discrimination required to support remedial action has ironically been swept away by legally mandated desegregation and relatively aggressive civil rights enforcement regarding public education. Racial discrimination is more likely to manifest itself, for example, in a racially hostile or insensitive educational environment rather than in flagrant *de jure*

educational segregation and deprivation. Therefore, if medical school affirmative action policies are to survive the strict scrutiny test, another foundation for the state's compelling interest in increased minority enrollment must be crafted and championed. Although the concept of diversity in medical school education is underdeveloped and under attack legally, it is the most promising constitutional defense of affirmative action in medical education.

### Diversity

The most important discussion of diversity as a constitutional justification for race-based admissions appeared in *Bakke*. Justice Powell declared that the University of California at Davis medical school's desire to create a diverse student body in order to provide more physicians for underserved minority populations did not constitute a compelling state interest sufficient to meet the strict scrutiny test. Powell (21) did not declare that providing physicians to underserved populations could never constitute a compelling state interest, but only that there was "virtually no evidence in the record indicating that petitioner's [the medical school] special admissions program is either needed or geared to promote that goal."

Powell's opinion leaves open the possibility that, given sufficient evidence, increased minority admissions might be deemed integral to increasing the number of physicians to care for underserved populations and thus might qualify as a compelling state interest. But medical schools never needed to employ this defense. There was another reason why the diversity justification might be considered a compelling state interest. Diversity, according to Powell (21), was a compelling state interest because it was vital for the "robust exchange of ideas." Powell's articulation of the diversity justification provided medical schools with the justification they required to pursue in good faith affirmative action practices based on race (33). The constitutional meaning of diversity in higher education remains a rarely discussed concept in case law and has never again been analyzed by a Supreme Court majority opinion. This lack of judicial analysis has undermined the diversity justification, as affirmative action programs face more frequent legal challenges.

The diversity justification was attacked directly in *University of Texas v. Hopwood* (11). The *Hopwood* opinion claimed that Powell's elevation of diversity as a compelling state interest in *Bakke* was never joined by the majority of the court and, as a result, did not represent the position

of the Supreme Court. The dissenters in *Hopwood* predicted that the “radical implications of this opinion, with its sweeping dicta, will literally change the face of public educational institutions throughout Texas, the other states of this circuit, and this nation (34, 35).” But the implications of *Hopwood* outside the Fifth Circuit are unclear. *University of Texas v. Hopwood* (11) is not the law of the land anywhere except the 5th Circuit. *Bakke* is. Besides *Bakke*, there are a number of important references to the diversity justification scattered in Supreme Court opinions (27). Even so, the diversity justification for educational affirmative action policies is clearly in need of revitalization.

Future courts may accept diversity as a compelling state interest if the justification is carefully articulated and supported by evidence provided by the legislatures or relevant governmental institutions. The special requirements of the doctor-patient relationship, the nature of race relations in the U.S. and the data that has become available in the last 20 years may help convince courts (and perhaps the public and legislatures as well) that diversity is a constitutionally legitimate motivation for enacting an affirmative action program. Diversity might be considered a compelling state interest in medical education for at least three reasons: (1) to increase the number of physicians who treat traditionally underserved patients and specialty areas; (2) to promote the robust exchange of ideas in medical education; and (3) to render better medical care to minority patients by providing them with physicians whom they can trust.

### **More Care for Underserved Patients**

Unlike in *Bakke*, there are now studies that help document that minority physicians care for a greater percentage of minority patients than do their white counterparts. Equally important, minority physicians more frequently serve communities with an insufficient number of physicians and care for a greater percentage of Medicaid and uninsured patients (36–40). These studies provide evidence that minority physicians benefit society as a whole by caring for populations that may otherwise lack sufficient medical professionals. Medical schools might supplement these studies with information gleaned from their own graduating classes. States have a compelling interest in improving the health of their citizens. Thus, a medical school might argue that affirmative action programs that produce more physicians for underserved communities serve a compelling state interest.

Even if courts view increasing minority physicians as a way to improve the health of

underserved populations, challenged programs would still have to meet an additional constitutional test: that the race-conscious measures are “narrowly tailored” to accomplish those goals. The defendant medical school would have to satisfy the finder of fact (court or jury) that the policy was reasonably limited in time and scope, that the cost to third parties had been calculated and was reasonable, and that there existed no race-neutral means to reach the same ends.

Are there race-neutral incentives that a state and its medical schools could use to bring physicians and healthcare to underserved regions? While the answer to this question is not immediately clear, it is a question that might have to be resolved if a medical school attempts to defend affirmative action policies on these grounds. Similarly, there may be race-neutral ways to increase the number of primary care physicians, the other apparent benefit of increasing the number of minority medical students.

But such a defense of diversity is disturbing on other grounds. Many minorities choose to serve underserved and sometimes remote populations as primary care practitioners. However, many minority physicians wish to follow other professional routes, for reasons of intellectual excitement, higher financial rewards or personal taste. That clearly is their right and society should be wary of a policy that suggests that African Americans be directed to specific demographic, geographic and economic strata of medical practice. This caveat does not necessarily mean that increased service to underserved groups cannot be used to help justify affirmative action policies. But the questions concerning this approach suggest that other defenses to diversity should be explored as well.

### **Cultural and Intellectual Diversity**

Powell also explained in *Bakke* (21) that diversity may be a compelling state interest because it leads to a “robust” exchange of experiences, outlooks and ideas that enrich the professional school and “better equip its graduates to render with understanding their vital service to humanity.” Diversity, he suggested, helps students develop better interpersonal skills by allowing them to interact with people of different perspectives and “communicate across the boundaries they create.” Thus, a diverse medical student population provides more than mere intellectual enrichment; it serves the practical function of better preparing non-minority medical students to care for an increasingly diverse patient population.

Minority medical students can help non-minority medical students understand the racially and culturally based concerns of minority patients.

Diversity in the educational arena is frequently defended as a means to enrich the intellectual experiences of students. However, the goal of better patient care is a far more compelling argument constitutionally than mere intellectual excitement in the classroom. And if an affirmative action policy is challenged legally, or even politically, evidence that such gains occur would be of vital importance. Again, such evidence may be difficult to acquire. Moreover, even if a court does agree that better patient care for minority populations represents a compelling state interest, the defendant medical school would have to show that its policy was "narrowly tailored" to serve that particular goal. The policy would have to be limited in scope and duration, and the school would be asked to show that it had considered race-neutral means of accomplishing the same goals. Are there textbooks that would aid in training non-minority physicians to thoughtfully care for their minority patients (41)? Would workshops, discussion groups, speakers or the use of standardized patients be sufficient, without resorting to race-based admissions practices (42)? Medical schools that defend their affirmative action policies on the grounds of better preparing their non-minority students for medical practice would be well advised to prepare answers to these questions in the event that their policies are challenged.

### **Like Doctor, Like Patient**

The third reason that diversity in the medical profession is a compelling state interest is that it is the most certain way to assure that minority patients will receive adequate health care. The state has an interest in the effective delivery of health care to all segments of the population. As a result, the state assumes a concomitant interest and duty to train physicians who can engage in mutually trustworthy therapeutic relationships with their patients. Minority groups, especially African Americans, have had a different historical experience with the medical profession than have non-minority patients. As a result, suspicion and misunderstanding, rather than trust, communication and empathy, seem to characterize many medical encounters between physicians and patients of different races or ethnic groups.

African American suspicion of the medical profession, Annette Dula has argued (43), "cannot be simply written off as paranoia or hypersensitivity." It has its roots in antebellum culture and con-

tinues into the present. Slaves could not reject or control health care and had limited control over their bodies (44). In addition, they were used as experimental subjects for painful and dangerous pharmacological and surgical remedies (45). These abuses instilled in the African American community a mistrust of the white medical profession that prevailed long after emancipation. Many in the medical profession subscribed to and developed 19th-century racial theories supporting the view that blacks were physically and mentally inferior to whites (46). Racism and race-based misconceptions regarding African American biology and physiology led to the infamous Tuskegee syphilis study, which continued in plain view of the white-dominated medical and scientific communities for more than forty years (47, 48). In addition, the bulk of the white medical profession acquiesced in, or actively advocated, the continuation of the formal and informal segregation of the health delivery system, a system which frequently delivered patently unequal care (49). The persistent legend that Dr. Charles Drew, a black pioneer in transfusion research, died after an automobile accident when he was refused "white" blood reflects the grim reality that generations of African Americans suffered and died because they did not receive adequate medical services in a segregated medical world (50). This continuing suspicion and skepticism has undermined the trust that should be central to the doctor-patient relationship.

Minority distrust of the medical profession is also related to their experience with the contemporary health care system. It is widely acknowledged that minorities, especially African Americans, have less access to health care services, higher mortality rates, and greater disease rates for a wide range of illnesses (51). While many of these disparities may be explained by differential socio-economic status, there is an extensive and growing literature that strongly suggests that stereotypes, prejudice and racism may still influence the medical care provided to minorities (52). There are studies that suggest that physicians treating minority patients are "less likely to follow guidelines from nationally recognized organizations for health promotion and disease prevention" than are physicians who care for predominantly white patients (53, 54). Other research reveals lower utilization rates for African Americans for ordinary components of basic medical care and reports that African American patients are more likely to feel that physicians failed to give them full information about their diagnosis, treatment and follow-up (55-57). Other studies have found that African Americans are more likely than

whites to be hospitalized for avoidable conditions (58), may receive a lower quality of care when hospitalized, and show more instability at discharge than do other patients (59, 60). African American patients receive fewer hip and knee replacements (61), are less likely to receive prophylactic therapy for HIV (62), are less likely to undergo surgical resection for colorectal cancer (63), and are less likely to receive angiography, angioplasty and coronary artery bypass surgery than white patients (64–69). In contrast, African Americans appear more likely to receive procedures patients typically wish to avoid, lower-limb amputation, bilateral orchiectomy and cesarean delivery (70). These racial disparities persist, in many cases, after controlling for social, economic and medical factors, leading many medical scholars to believe that some form of prejudice or bias may be at work (71, 72). The authors of one racial disparity study (73) concluded that their findings “suggest inappropriate influences on clinical decision making that would not be addressed by changes in reimbursement.” Another commentator noted that the treatment disparities in cardiac care raised the “probability” of “covert or unconscious racial stereotyping by physicians (52). The *New England Journal of Medicine* recently reported a study involving standardized patients that found that the race of the patient independently influenced the diagnosis and treatment recommendations of the physicians. The authors concluded (74) that such findings “may represent overt prejudice on the part of physicians or, more likely, could be the result of subconscious perceptions rather than deliberate actions or thoughts.”

### The Role of Trust

Physicians require the trust of patients in order to treat them effectively. According to Edmund Pellegrino (75), trust is a central component of medical professionalism:

Those in need must trust that their vulnerability will not be exploited. Professionals must invite that trust because without it, they cannot obtain the information they need to provide assistance or the sanction to undertake delicate and dangerous procedures that put body, property, or spirit at risk.

Unfortunately, the suspicion born of historical experience, the growing empirical evidence showing differential treatment and disparate results, and scattered and common anecdotal accounts give minority patients tenable grounds on which to

question the good will and color blindness of white medical practitioners. These suspicions, whether true or not in any individual case, can thwart the doctor-patient relationship, which should be based on trust and the expectation that the physician will act in the best interest of the patient.

Minority distrust of the medical profession may also affect the health of African Americans by influencing such factors as patterns of compliance, preventive care, and patient disclosure of information and choice of therapies (43). For example, one study found that African Americans believed that racism was a key reason that black health indicators consistently lag behind those of whites (76). As one African American publication (77) states, “black distrust of the medical community runs deep.” Mistrust of the medical profession is a commonly cited reason why African Americans frequently hesitate to donate organs or complete advance directives (78). Viola Clark-Goodwin, a community health worker, warns African Americans that “Stereotypes and assumptions need to be put in their place. Don’t fall for any doctor telling you that you look a certain way, therefore, you should be or must be a certain way. Question every specialist’s opinion regarding your health.” Clark-Goodwin (79) advises African Americans to “seek out a friend or a peer you can trust, someone of your own ethnicity, someone who speaks your language.” African Americans should not be forced to rely on friends and peers for medical advice and comfort. They should be able to rely on trained physicians.

The foregoing comments suggest that this suspicion is so deep-seated and widespread that, in the short term, the only remedy is to provide minority patients with physicians with whom they will feel safe and comfortable. Not surprisingly, minorities, when asked, usually prefer to be treated by physicians from their own ethnic groups (80). As former U.S. Secretary of Health and Human Services Louis Sullivan recently observed (81), the country has a “social and moral obligation to cultivate physicians who can relate to that segment of the community.” Building on Sullivan’s premise, it should be possible to craft and support an argument that the state has a compelling interest in producing physicians who can treat its citizens effectively. Some federal courts have recognized the utility and importance of diversity in law enforcement agencies that are charged with working with diverse populations (82). Like physicians, law enforcement officers must possess the trust of the persons in the community they serve in order to

get the information, compliance and legitimacy they require to do their jobs appropriately.

It is unclear whether courts will accept the need to produce more physicians of color as a reinvigorated justification of diversity and as a compelling state interest. But it will likely be easier to collect evidence in defense of diversity than to prove that affirmative action policies are required in order to remedy the effects of past or current discrimination. There is abundant evidence that minorities have a fundamentally different experience with the health care system than do majority patients. Further studies investigating disparate treatment and minority patient preferences and fears would be central in demonstrating the state's interest in a diverse medical profession. Qualitative and quantitative evidence demonstrating the impact that racially diverse health care teams have on patient comfort and trust would also buttress this argument.

### Regarding Merit

One of the central attacks on affirmative action is focused on the assertion that preferential policies undermine the democratic ideal of advancement based on merit. Moreover, critics of affirmative action claim that acceptance of less meritorious candidates into medical schools has human costs in the form of less qualified physicians. As Jeffrey Jacoby contends (6), "Minority communities and poor families don't need black doctors. They need good doctors." It is possible, of course, that they could need both. Merit-based attacks on affirmative action are fueled by the fact that African American median MCAT scores and GPAs are frequently lower than those of white medical school matriculants (83).

Merit seems to have two meanings in the context of admissions to medical schools: (1) that individuals "deserve" admission as a reward for performance of some sort; and (2) that individuals should be chosen for particular roles or endeavors because their qualifications are evidence that they are better suited to fulfill the job requirements than other individuals (84). There appears to be a widespread assumption that a strict, competitive meritocracy preceded the affirmative action efforts of the last 30 years in professional schools. That, however, is not the case. MCAT scores were introduced in the 1950s, not to predict who would be the best physicians, but rather to reduce the attrition rate that had ballooned as a result of relatively open (for whites) admissions policies at most medical schools. As the pool of well-prepared students increased in the 1960s and 1970s, competition for

admissions slots increased. The mean MCAT score of matriculants rose accordingly, beyond what was necessary to guarantee reasonably successful completion of a course of medical studies (85). Thus, while such criteria as MCAT scores and GPAs are frequently taken as objective measures of which students will be the better physicians, they were instituted by the medical education establishment for entirely different reasons, i.e., to ensure that matriculants could successfully complete a rigorous course of study. Recent studies have confirmed that students with lower MCATs and GPAs who receive admission preferences sometimes struggle in the basic science courses and are more likely to retake the U.S. Medical Licensure Examination (USMLE). However, they graduate at virtually the same rate as non-preferential matriculants and receive similar evaluations from residency directors (86). There is no empirical evidence that matriculants with lower test scores turn into inferior doctors and provide inadequate health care for their patients. Thus, as designed, such measures serve as an efficient and objective predictor of who will be able to complete the course of study. But they do not appear to be accurate evidence of how well a particular individual can perform his or her required professional function—taking care of patients.

What then are relevant indicators of merit, of which applicants are better suited to fulfill the duties of a practicing physician? GPAs and MCAT scores clearly provide relevant information. But are there other important considerations? Some observers reason that minority physicians increase the "user friendliness" of the health care system and the trust of the minority patient population, thereby increasing accessibility. Minority practitioners may also prove more "culturally sensitive to their populations and organize the delivery system in ways more congruent with the needs of minority populations." (40). As Louis Sullivan has explained (87), "Attitudes such as understanding the patient's culture, empathy for the patient, and integrity of the physician inspire trust, and a combination of science and art are important because medicine involves the most personal kinds of decisions we can make." Thus, those critics who claim that race-conscious admissions policies undermine or scorn merit appear to miss the point. In short, an affirmative action argument based on patient-well being "is" a merit-based argument, in that race may be directly related to the medical school applicant's ability to practice good medicine. It may be difficult to measure the impact and patient benefit of increasing the number of minority physicians, but

it is reasonable and fair to deduce that such benefits will accrue. It is also fair to weigh those benefits against the potential costs of affirmative action programs. Although this will be a difficult and uncertain calculation, its solution could play a critical role in defending affirmative action policies, legally and politically. The costs of such programs, if considered honestly and soberly, are likely to be outweighed by the promise of providing better care for all patients.

### Conclusion

Medical schools should use all viable arguments in order to defend legitimate and well-designed affirmative action practices. If institutions can demonstrate that their policies are justified on the grounds of remedying the effects of past or current discrimination or distributive justice, they should do so. In the current legal and political environment, however, these arguments will be less likely to win judicial support than ones based on the state's compelling interest in providing sufficient medical care for its citizens by increasing the diversity of the physician population. Moreover, a carefully restated diversity argument, for a number of reasons, will be more likely to win the minds, if not the hearts, of the public and thus pacify at least some of the political opposition to affirmative action in higher education.

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