Affirmative action ends: How Supreme Court ruling impacts medical schools & the health care workforce [Podcast]

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The U.S. Supreme Court’s ruling ending affirmative action will have a significant impact on medical education and diversity in medicine. Joining to discuss the implications are Sanjay Desai, MD, AMA’s chief academic officer and group vice president of medical education, and Dave Henderson, MD, AMA’s vice president for equity, diversity and belonging in medical education. American Medical Association Chief Experience Officer Todd Unger hosts.

Speakers

- Sanjay Desai, MD, AMA chief academic officer and group vice president of medical education
- Dave Henderson, MD, AMA vice president for equity, diversity and belonging in medical education

Transcript

Unger: Hello, and welcome to the AMA Update Video and Podcast series. Today, we're talking about the Supreme Court's ruling on affirmative action and its impact on medical education. I'm joined by Dr. Sanjay Desai, AMA's chief academic officer and group vice president of medical education in Chicago. We also have Dr. Dave Henderson, AMA's vice president for equity, diversity, and belonging in medical education, calling in from West Hartford, Connecticut. I'm Todd Unger, AMA's chief experience officer, also in Chicago.

Welcome, Dr. Desai, Dr. Henderson.
Dr. Desai: Thank you so much, Todd, for having us here for this important topic.

Dr. Henderson: Thank you very much, Todd. It’s great to be here.

Unger: Dr. Desai, let’s start with you first, a little background, with its ruling on affirmative action, the Supreme Court has upended decades of legal precedent, which will have a significant impact on higher education including medical education. Dr. Desai, can you start by giving us an overview of the court’s ruling?

Dr. Desai: Sure, Todd. I think, hopefully, as many people have probably read by now in the news, last Thursday, almost a week ago, the Supreme Court struck down affirmative action programs at the University of North Carolina and at Harvard University, judging it illegal to use race as a consideration in the admissions process. They essentially ruled that it violates the Equal Protection Clause of the Constitution.

The vote was 6 to 3 in the case with University of North Carolina and 6 to 2 in the case with Harvard because Justice Ketanji Brown Jackson recused herself from that latter case.

Unger: Now the AMA has been tracking this case and actually filed an amicus brief. Dr. Desai tell us a little bit more about that, and the AMA stance on the ruling.

Dr. Desai: The AMA’s had a loud voice in this. We joined more than 40 other organizations alongside the amicus brief that was filed by the Association of American Colleges and essentially urged the Supreme Court, Todd, to take no action that would disrupt the admissions processes that the nation’s health professional schools have carefully crafted in reliance on this court’s long standing precedents.

You refer to the precedents yourself and that amicus brief was cited by the dissenting justices in their comments on this case. And we feel policies that permit race as a component of selection are critical to diversifying the health care workforce.

Unger: Thank you, Dr. Desai. Dr. Henderson, what impact will this ruling have on medical education and the diversity of future med school classes?

Dr. Henderson: Well, Todd, it’s likely to have a significant impact because affirmative action has been much more effective than any of the other strategies that have been employed. There have been some race neutral strategies that have been employed and have been studied. As an example, affirmative action sort of provides about a 20% increase in diversity, according to a number of studies.

There are also strategies of holistic review that aren’t inclusive of race and they bump matriculation and diversity in medical schools about 7%. In addition, there are test optional policies, policies that don’t require, say, SAT scores for entry into undergraduate education. And in a study in 2022, they...
found that they only increased diversity by 1%.

And there are a number of states that have sort of top 10% of plans, states that have passed legislation that allow the students in the top percent of their graduating class in high school to be admitted to any of the state institutions. And in a study of those plans, they found a lot of mixed results. Specifically, they found that there were many instances in which students sort of under-enrolled, that is to say, they chose institutions other than the top tier schools in their state, even though they qualified for admission there.

It should also be noted, I think, that there are large racial gaps in kindergarten readiness between students from affluent neighborhoods and students from poor communities. And these gaps in achievement actually continue throughout K to 12 education. So if you are a poor child, if you are from a group that’s underrepresented and disadvantaged, you have challenges from the time you begin education in this country in kindergarten.

**Unger:** So that’s quite a pipeline problem that you’re talking about there and real concern that a change like this is going to lead to a less diverse medical school class. Now, that follows that we might be then seeing a much less diverse physician workforce.

Dr. Desai, why is that a problem? And why is it an issue when we think about delivering better patient care?

**Dr. Desai:** This relates directly to the health of our country. Systemic and structural racism are major contributors to the existing health inequity that we see in this country. Ameliorating racism must be central to our workforce development strategy if we hope to make progress towards achieving health equity. So while our country continues to grow more and more diverse, historically marginalized communities have been left behind on nearly every health indicator.

A physician workforce that reflects the diversity of the nation is key to eliminating those health inequities. And there’s convincing evidence, there are data for this, Todd, there’s evidence that racially diverse care teams produce measurably positive health outcomes for patients in historically marginalized populations. Patients in minority communities, they demonstrate improved primary care management, adherence and health behaviors when clinicians have race concordance.

And this has been noted by Justice Jackson in her dissent, that racial concordance between high risk Black newborns and physicians was associated with decreases in mortality. And the goal, to be clear, is not that we create a system of racially segregated care, but rather a health care workforce, Todd, in which racial and ethnic representation is a more common aspect of our care teams.

**Unger:** So it’s clear that diversity can improve patient outcomes. But in most places, those outcomes are not yet a reality for patients, as you’re kind of laying out already. What is the level of diversity in
our current physician workforce? And where does it need to be?

Dr. Desai: In the United States the demographics of the current health care workforce do not align with the demographics of the population. According to the latest data from the Association of American Medical Colleges, only 6.9% of physicians in the United States identify as Hispanic, while 5.7 identify as Black or African American, and only 0.3% of physicians identify as American Indian or Alaska Native.

However, if you look at the population, almost 20% of the U.S. population identifies as Hispanic or Latino, over 13% identify as Black or African American. And over 1.3% identify as American Indian or Alaskan Native. And between 1997 and 2017, the number of matriculants to medical school from underrepresented groups declined, declined, Todd, by 16%, a big gap.

Unger: So we're already seeing major challenges even with affirmative action in place. Dr. Henderson, what are some of the biggest barriers that we're up against in getting a more diverse group of medical school applicants and graduates?

Dr. Henderson: As I sort of alluded to before, there are inequities in K-12 education, in the way that our public education system is structured, being funded by local taxes. So if you live in a poor neighborhood, you are more likely to attend an under-resourced school. I think the issue of diversity in higher education, which creates a pipeline that provides matriculants to medical school, universities and colleges can't manage the work of diversifying the workforce by themselves.

The solution can't be found in a patchwork of state level policies. Action from the federal government is required. And it needs to begin well before high school, which is where a lot of pathways programs start.

Unger: So with all of those kind of barriers that you're outlining and the loss of affirmative action, what are some of the ways that medical schools can still increase diversity at their institutions?

Dr. Henderson: Well, I think there are a number of possible options for schools. One option is to advocate within their state for better K to 12 education to eliminate some of the existing inequities. That will take a long time but if successful, that will actually create the pipeline or the pathway that is needed. Additionally, I think that there needs to be closer collaboration between medical schools and graduate schools in general, and their undergraduate institutions locally, again, to help foster the creation of a pathway.

And in addition to that, medical schools, universities need to really advocate very strongly at a state level for improved education throughout the continuum, because that I think, is the best way forward for us. Another pool of potential applicants that's often overlooked are students who begin their education in community colleges. I think making inroads and creating relationships with community
colleges is another sort of important mechanism for bringing a more diverse applicant pool to medical school admissions.

**Unger:** What about, let's think about folks that are submitting their applications and having a more holistic review. What's that look like?

**Dr. Henderson:** Well, there are a number of approaches for that. And some schools have started to use adversity metrics. It could be said that everyone walks a mile to come to the door of medical education, but some people walk much longer miles and much harder miles than others. And I think taking a look at what a given student has had to overcome and taking that into consideration, I think can help identify some very worthy students that might be overlooked in more normative, race neutral admissions settings.

**Unger:** Dr. Desai, this is an issue the AMA has been working on long before the Supreme Court decision. Can you talk about how the AMA is supporting efforts to increase diversity in our physician workforce?

**Dr. Desai:** Todd, as you mentioned this is a core issue for us. Thankfully, we have a long standing history of supporting diversity in medical schools. We have a substantial body of policy that supports equity, diversity and belonging in medical schools and diversification of the medical student body, and using race conscious practices in admissions. In fact, at our annual meeting just a month ago, this was reaffirmed.

Within medical education, we work across the AMA, with our Center for Health Equity, as well as with other areas within the American Medical Association, to really do as much as we can to promote the diversification of medical student body and the physician workforce. Some examples include education content, so we are leading, really, the dissemination of health system science. How do we educate our physicians on the health system?

And within that, there is a core content area related to structural drivers of health, where things such as structural racism and the need for a diversified workforce comes in. We also have programming on combating structural racism in both medical schools as well as in residency programs and offer guidance on how to combat these to help our partners who are educating physicians and developing them across the country.

We have helped these same universities develop research and action plans to understand the challenges to developing a diversified student body and physician workforce. We've hosted webinars with experts from across the country, to promote awareness in this space and to help disseminate and learn best practices related to this issue.


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We have a Council of Medical Education, Todd, that's quite active in the country and they've produced reports describing promising practices on pathway programs that Dr. Henderson was just describing. We're currently, actually, leading the creation of a study that is looking at how to embed and promote racial justice in medical education. A component of that will certainly be this topic. And we're organizing a proposal now to, particularly on the heels of this judgment, to identify and disseminate practices around diversifying the medical student body.

So many areas in which the American Medical Association is active in this space. But I would just take one step back. This is a space where I believe everybody is humbled. It is an overwhelming problem and in my view, is a problem beyond diversity, it's a problem about health equity and health.

And so as much as we are doing, we also recognize and are trying our best to partner with other organizations, with universities, with health systems, with others that see this as urgent of an issue as we do, because we think only through collaboration, given the complexity of this issue, are we going to be able to have the change that we aspire to have as quickly as we all believe that it's necessary.

So our hopes in this space are ambitious and urgent. But the space itself is quite overwhelming, and so we're eager to continue this work.

Unger: Well, thank you so much, Dr. Desai and Dr. Henderson, for your perspective on this important change. I appreciate you joining us today. That wraps up today's episode. We'll be back soon with another segment. In the meantime, you can find all our videos and podcasts at ama-assn.org/podcast. Thanks for joining us. Please take care.

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