# Advisory

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Date: August 16, 2012

To: Board of Directors
Council of Deans
Council of Teaching Hospitals and Health Systems
Council of Academic Societies
Organization of Student Representatives
Organization of Resident Representatives
Medical Center Leaders Caucus
Chief Medical Officers Group
Compliance Officers Forum
Forum on Conflicts of Interest in Academe
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Group on Information Resources
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Group on Institutional Planning
Group on Regional Medical Campuses
Group for Research Advancement and Development
Group on Resident Affairs
Group on Student Affairs
Group on Women and Medicine in Science

From: Darrell G. Kirch, M.D., President and CEO

Subject: AAMC *Amicus Curiae* Brief in *Fisher v. University of Texas*

For the second time in a decade, the AAMC has joined with a distinguished group of 29 other educational and health professional organizations to reinforce with the Supreme Court the well-established connection between a diverse student body and a health care workforce that is best prepared to reduce health disparities and ensure the health of all.

The nexus between diversity in medical education and the advancement of health care equity in the United States has driven the AAMC's strategic priority of leading efforts to increase diversity in medicine. As explained by Justice Powell in the Supreme Court case of *Regents of the University of California v. Bakke* nearly 34 years ago:

> "Physicians serve a heterogeneous population. An otherwise qualified medical student with a particular background – whether it be ethnic, geographic, culturally advantaged or disadvantaged

> – may bring to a professional school of medicine experiences, outlooks, and ideas that enrich the training of its student body and better equip its graduates to render with understanding their vital service to humanity."

Following the framework outlined in *Bakke* and upheld by the Supreme Court in 2003 in *Grutter v. Bollinger*, the AAMC and its member medical schools have striven to ensure that holistic admissions practices that incorporate race as one of many personal attributes considered when reviewing an applicant's background are in full alignment with the Supreme Court's guidance.

The *Fisher* case involves a challenge to the University of Texas at Austin's consideration of race in undergraduate admissions. The Court is being asked to invalidate the Texas process under the Court's 2003 decision in *Grutter* or, alternatively, to revisit the *Grutter* case's holding.

The possibility of the Court revisiting the 2003 *Grutter* decision is a cause for concern. A change in legal standards at this time could disrupt or otherwise require changes to the admissions processes, possibly resulting in fewer under-represented minority medical students, therefore jeopardizing our nation's ability to serve the health care needs of all Americans.

The Court accepted the Fisher case for oral argument in its Fall term for October 10, 2012. A copy of the amicus brief, filed with the Court on August 13, is attached. Questions may be directed to Marc Nivet, AAMC chief diversity officer, at 202-862-6022, mnivet@aamc.org; Frank Trinity, AAMC chief legal officer, at 202-828-0540, ftrinity@aamc.org; or Heather Alarcon, AAMC corporate counsel, at 202-828-9939, halarcon@aamc.org.

No. 11-345

IN THE

# Supreme Court of the United States

ABIGAIL NOEL FISHER,

*Petitioner*,

v.

UNIVERSITY OF TEXAS AT AUSTIN, et al.,

*Respondents.*

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

**BRIEF FOR AMICI CURIAE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ET AL. IN SUPPORT OF RESPONDENTS**

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

## BRIEF FOR AMICI CURIAE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ET AL. IN SUPPORT OF RESPONDENTS

## INTEREST OF AMICI CURIAE

The **Association of American Medical Colleges** ("AAMC") is a nonprofit educational association whose members include all 138 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems; and 90 academic and scientific societies.[1] Through these

[1] No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than the amici curiae or their counsel made a

institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians. Founded in 1876, the AAMC, through its many programs and services, strengthens the world's most advanced medical care by supporting the entire spectrum of education, research, and patient care activities conducted by its member institutions.

AAMC is joined in this brief by eleven organizations whose members include schools, residency programs, and other institutions involved in educating and training health care providers and administrators: the **American Association of Colleges of Nursing**, **American Association of Colleges of Osteopathic Medicine**, **American Dental Education Association**, **Associated Medical Schools of New York**, **Association of Academic Health Centers**, **Association of American Veterinary Medical Colleges**, **Physician Assistant Education Association**, **Association of Schools of Allied Health Professions**, **Association of Schools of Public Health**, **Association of University Programs in Health Administration**, **and National Association of Hispanic-Serving Health Professions Schools, Inc.**; fourteen organizations whose members include physicians and other health care providers: the **American Medical Association**, **American Dental Association**, **American Nurses Association**, **American Academy of Family Physicians**, **American Academy of Pediatrics**, **American Academy of Physician Assistants**, **American College of Obstetricians and**

monetary contribution to its preparation or submission. The parties have consented to the filing of this brief.

**Gynecologists**, **American College of Physicians**, **American Psychiatric Association**, **American Public Health Association**, **Association of American Indian Physicians**, **National Hispanic Medical Association**, **National Medical Association**, and **Society of General Internal Medicine**; three organizations that represent the interests of medical school students: the **American Medical Student Association**, **National Medical Fellowships, Inc., Student National Medical Association**; and **The ASPIRA Association, Inc.**, a non-profit organization that is dedicated to improving the health of underserved communities. Additional information regarding these organizations is provided in the Addendum to this brief.

## SUMMARY OF THE ARGUMENT

At its best, the quality of medical care in the United States is unmatched throughout the world, in large part because of its unparalleled medical education institutions. As the gatekeepers to the medical profession, medical schools have obligations that extend beyond their individual students to society at large. Those obligations include redressing current disparities in health care, where minority patients tend to receive less and lower quality care than others. The Nation's medical schools must ensure not only that graduating physicians will be able to practice medicine at the highest levels, but also that competent medical care in different practice areas will reasonably be available to all who need such care.

Medical schools have learned over many decades of experience that these goals cannot be accomplished unless physicians are educated in environments that reflect the ever-increasing diversity of the society

they serve. As a result, access to medical education has never been determined solely by metrics such as test scores and grades. Rather, admission has historically been based on a holistic evaluation process—including personal interviews of applicants—in which an applicant's background is taken into account along with myriad other factors.

In *Regents of the University of California* v. *Bakke*, 438 U.S. 265 (1978), the Court approved of this holistic evaluation process, with Justice Powell providing the deciding rationale. As he explained:

> Physicians serve a heterogeneous population. An otherwise qualified medical student with a particular background—whether it be ethnic, geographic, culturally advantaged or disadvantaged—may bring to a professional school of medicine experiences, outlooks, and ideas that enrich the training of its student body and better equip its graduates to render with understanding their vital service to humanity.

*Id*. at 314 (Powell, J.). Twenty-five years later, the Court specifically endorsed Justice Powell's rationale, after observing that "[p]ublic and private universities across the Nation have modeled their own admissions programs on Justice Powell's views." *Grutter* v. *Bollinger*, 539 U.S. 306, 307 (2003). *See also id*. at 387 (Kennedy, J., dissenting) ("The opinion by Justice Powell, in my view, states the correct rule for resolving this case.").

Justice Powell's words ring as true today as they did thirty-five years ago. Indeed, the need to train the next generation of physicians in a diverse educational environment is even more important

now, as our society has become even more heterogeneous. Research shows that when physicians understand more about the diverse cultures of their patients, physician decision-making is better informed, patients are more likely to follow their physicians' advice, and medical outcomes improve. Thus, preventing medical educators from continuing to value diversity will not merely impoverish the educational experience of all future doctors; it will diminish their ability "to render with understanding their vital service to humanity." *Bakke*, 438 U.S. at 314 (Powell, J.).

In the nearly thirty-five years since *Bakke*, medical schools throughout the Nation have been refining and implementing holistic methods for evaluating applicants of the type approved by Justice Powell and later endorsed by the Court. In evaluating an applicant's ability to contribute to and benefit from an enriching educational environment, race is considered merely as one of a multitude of factors, none of which is dispositive standing alone. Whereas petitioner focuses on test scores and grades as the almost exclusive barometer of merit, those factors have never been independently determinative in medical school admissions. The goal is not mechanically to admit students based on numerical criteria or to mirror the country's demographics, but rather to produce a class of physicians that is best equipped to serve *all* of society.

There is no proven substitute for this individualized, holistic review that may consider an applicant's race and ethnicity along with all other factors that make up his or her background. As this Court recognized in *Grutter*, 539 U.S. at 340, for medical schools and other graduate institutions there is

nothing akin to respondent's "Top 10%" plan, which achieves a degree of diversity only because of underlying residential segregation in Texas. Medical school administrators have found no other proxy that could substitute for individualized consideration of an applicant's entire background.

Dating to *Bakke* and continuing through *Grutter*, the Nation's medical schools have relied on this Court's approval of the legal framework supporting their holistic, individualized evaluation process, which furthers the schools' societal obligation to ensure that physicians will be competent to serve their increasingly diverse patients. Accepting petitioner's invitation to overrule these decisions, or to remove the deference to expert educators that underlies them, would effectively prevent medical schools from fully carrying out that obligation, to the detriment of patient health. Accordingly, amici urge this Court to take no action that would disrupt the admissions processes that have been carefully crafted in reliance on these longstanding precedents.

## ARGUMENT

### I. DIVERSITY IS A VITAL COMPONENT OF THE EDUCATIONAL MISSION OF THE NATION'S MEDICAL SCHOOLS.

#### A. Physicians Must Understand How To Serve Diverse Communities.

The current picture of health in America is simultaneously bright and bleak. While we are better equipped than ever with biomedical knowledge and technology to both avoid disease and prevent early death, certain segments of the population are slow to benefit from these advancements.

Significant health disparities exist along lines of socio-economic status, urban or rural residence and, most notably, race and ethnicity. *See* Bruce G. Link, *Epidemiological Sociology and the Social Shaping of Population Health*, 49 J. of Health & Soc. Behav. 367 (2008). Minority populations continue to disproportionately suffer from numerous health conditions. In some areas, such as maternal death and the diagnosis of advanced-stage breast cancer, the disparities have increased. *See* Centers for Disease Control and Prevention, *CDC Health Disparities and Inequalities Report—United States* (2011) (www.cdc.gov/mmwr/pdf/other/su6001.pdf); HHS, Agency for Healthcare Research & Quality, *National Healthcare Disparities Report* (2011) (www.ahrq.gov/qual/nhdr11/nhdr11.pdf). When new technologies emerge to fight a disease, minority populations experience substantially slower and fewer benefits than non-minorities. *See* Link, *supra*. While some of these disparities are due to lower levels of health care in minority communities, the disparities persist even in systems where access is universal, such as in veterans' care. *See* H.P. Santry & S.M. Wren, *The Role of Unconscious Bias in Surgical Safety and Outcomes*, 92 Surg. Clin. N. Am. 137 (2012).

Moreover, minority communities are both medically underserved and served disproportionately by physicians of their own race or ethnicity. Communities with high proportions of African-American and Hispanic residents are far more likely to have a shortage of physicians, regardless of income. *See, e.g.*, J.S. Weissman et al., *Residents' Preferences and Preparation for Caring for Underserved Populations*, 78 J. Urban Health 535 (2001); *see also* Karen Odom Walker et al., *The Association Among Specialty,*

*Race, Ethnicity, and Practice Location Among California Physicians in Diverse Specialties*, 104 J. Nat'l Med. Assoc. 46 (2012). Underserved residents also rely heavily on underrepresented minority physicians for their care, because relatively few non-minority physicians practice in those areas. *See* Somnath Saha & Scott A. Shipman, *Race-Neutral Versus Race-Conscious Workforce Policy To Improve Access To Care*, 27 Health Aff. 234 (2008); William T. Basco Jr. et al., *Assessing Trends in Practice Demographics of Underrepresented Minority Pediatricians, 1993–2007*, 125 Pediatrics 460 (2010).

These disparities cannot continue. It is estimated that by 2015 there will be a shortage of 63,000 physicians in the United States, a number that is projected to rise to 130,000 by 2025. *See* AAMC, *The Impact of Health Care Reform on the Future Supply and Demand for Physicians: Updated Projections Through 2025* (2010) (www.aamc.org/download/158076/data/updated_projections_through_2025.pdf). This demand for providers is true of the nursing profession as well. It is expected that the number of employed nurses will grow from 2.74 million in 2010 to 3.45 million in 2020, an increase of 712,000 or 26%. Bureau of Labor Statistics, *Employment Projections 2010-2020* (2012) (www.bls.gov/news.release/pdf/ecopro.pdf) (Table 6). In 2012, only 15% of students in U.S. medical schools and 23% of nursing students are underrepresented minorities, while such minorities comprise 36% of the total U.S. population, with that number expected to increase. *Compare* AAMC, *Total Enrollment by U.S. Medical School and Race and Ethnicity, 2011* (www.aamc.org/download/160146/data/table31-enrll-race-sch-2011.pdf), *with* William H. Frey, *America's Diverse Future: Initial*

*Glimpses at the U.S. Child Population from the 2010 Census* (Brookings 2011), *and* Congressional Research Service, *The Changing Demographic Profile of the United States* 18-22 (2011); Amer. Assoc. of Colleges of Nursing ("AACN"), *2011-2012 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing* 21 (2012). It is therefore plain that health professionals of all races and ethnicities must learn to better serve the country's diverse patient population in order to reduce disparities in health outcomes.

The Nation's medical schools believe that the key to eliminating the health disparities described above is to develop a workforce of people from all backgrounds to bridge the current differences between providers and patients. In addition to graduating physicians with the highest medical skills, medical schools also seek to train physicians with high levels of "cultural competence." These are physicians who are familiar with the connection between socio-cultural factors and health beliefs and behaviors and who have the tools and skills to manage these factors appropriately to help eliminate socio-cultural barriers to care. Joseph R. Betancourt et al., *Defining Cultural Competence: A Practical Framework for Addressing Race/Ethnic Disparities in Health and Health Care*, 118 Pub. Health Rep. 293, 298 (2003).

Nursing programs across the country have also placed greater importance on educating a culturally competent workforce. The objective is to educate and train students to provide patient-centered care that identifies, respects, and addresses differences in patients' values, preferences, and expressed needs. *See* AACN, *Cultural Competency in Baccalaureate Nursing Education* (2008) (www.aacn.nche.edu/

leading-initiatives/education-resources/competency .pdf); AACN, *Establishing a Culturally Competent Master's and Doctorally Prepared Nursing Workforce* (2009) (www.aacn.nche.edu/education-resources/CulturalComp.pdf). These efforts also further the profession's objective of eliminating health disparities that nurses must address in a global environment, in partnership with other healthcare disciplines. HHS, National Committee of Vital and Health Statistics, *Eliminating Health Disparities: Strengthening Data on Race, Ethnicity, and Primary Language in the United States* (2005) (www.cdc.gov/nchs/data/misc/EliHealthDisp.pdf).

Medical schools strongly believe that diversity in the educational environment is integral to instilling in new physicians the cultural competence necessary to more effectively serve a diverse society. Contrary to petitioner's contention, medical educators are not prohibited from valuing diversity in order "to advance the general welfare of society." Pet. Br. 29. Medical schools are committed to creating a diverse educational environment because they believe that a diverse student body produces educational outcomes that ultimately benefit public health. "[M]uch of the point of education is to teach students how others think and to help them understand different points of view—to teach students how to be sovereign, responsible, and informed citizens in a heterogeneous democracy." Akhil Reed Amar & Neal Kumar Katyal, *Bakke's Fate*, 43 UCLA L. Rev. 1745, 1774 (1996). For medical schools, the educational benefits of diversity are fundamentally necessary to improve health outcomes throughout the United States. A diverse classroom "provide[s] a unique contribution to learning, discussion, and understanding that is

not necessarily attainable elsewhere." Lisa Tedesco, *The Role of Diversity in the Training of Health Professionals*, in *The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in the Health Professions* at 36, 50 (Inst. of Medicine 2001). Furthermore, opportunities for mentoring of students by diverse medical leaders are also essential to an inclusive learning environment. David A. Thomas, *The Truth About Mentoring Minorities: Race Matters*, 79(4) Harv. Bus. Rev. 98 (2001).

Just as Justice Powell recognized more than three decades ago, amici remain convinced that because "[p]hysicians serve a heterogeneous population" they must be educated in a medical school that includes students of *all* backgrounds, who bring "outlooks, and ideas that enrich the training of its student body and better equip its graduates to render with understanding their vital service to humanity." *Bakke*, 438 U.S. at 313 (Powell, J.). As discussed further below, medical schools continue to carry out that societal obligation by employing the holistic admissions process approved by Justice Powell and later endorsed by the Court, which properly considers an applicant's entire background without predetermined quotas or outcomes.

### B. The Benefits Of Diversity Are Indispensable To Achieving Core Educational Goals.

Diversity in medical school admissions is not an end goal in itself, but rather a means to achieving the core educational goals defined by the institution. *See* Amy N. Addams et al., *Roadmap to Diversity: Integrating Holistic Review Practices into Medical School Admission Processes* ("*Integrating Holistic Review Practices*") at ix (2010) (www.aamc.org/

publications). While diversity may include race, ethnicity, and gender, it is a "student-specific, multidimensional concept" that "may encompass other dimensions of experiences and attributes" including, among other things, an applicant's having overcome hardships or cultural barriers, languages spoken, socioeconomic status, and geography. *Id.*

This flexibility means that diversity is not a "one-size-fits-all" concept. Just as it can encompass a variety of factors within a single school, it may have different meanings from one school to the next. Depending on the "institutional mission, educational goals, the kind of students a medical school wants to educate, and the kind of physicians it wants to graduate," the diversity interests of one medical school may be markedly different from those of another. *Id.* While their practices will likely share common elements, each school must individually determine how best to apply principles of diversity in pursuit of its goals as an institution. "The key to success for any medical school seeking to enroll and graduate a broadly diverse class is the connection the school makes between the diversity it seeks and the educational, mission-driven goals to which it aspires." Arthur L. Coleman et al., *Roadmap to Diversity: Key Legal and Educational Policy Foundations for Medical Schools* at vi (2008) (www.aamc.org/publications).

For most medical schools, these goals include producing culturally-competent physicians who are well-adapted to serve patients from across the varied racial and ethnic makeup of the Nation. As this Court recognized in *Grutter*, "numerous studies show that student body diversity promotes learning outcomes, and 'better prepares students for an

increasingly diverse workforce and society, and better prepares them as professionals.'" 539 U.S. at 330 (citation omitted). Business skills "can only be developed through exposure to widely diverse people, cultures, ideas, and viewpoints." *Id.* "In order to cultivate a set of leaders with legitimacy in the eyes of the citizenry, it is necessary that the path to leadership be visibly open to talented and qualified individuals of every race and ethnicity." *Id.* at 332. These fundamental benefits of diversity have not changed since the Court recognized them nearly a decade ago.

In the medical education environment, these benefits are particularly important because public health is at stake, not just business interests. A diverse student body helps to promote the empathy, emotional intelligence, and cultural competence required of physicians and other health care professionals. Medical students who are educated in a diverse student body report that they are better able to work with patients of diverse backgrounds. Gretchen Guiton et al., *Student Body Diversity: Relationship to Medical Students' Experiences and Attitudes*, 82 Acad. Med. 51 (2007); *see also* Somnath Saha et al., *Student Body Racial and Ethnic Composition and Diversity-Related Outcomes in US Medical Schools*, 300 JAMA 1135 (2008) (finding that non-minority students attending more racially diverse medical schools exhibited greater confidence in their preparedness to care for minority patients and stronger attitudes about equitable access to health care). The benefits are even greater when students engage in informal discussions about course materials with peers from diverse backgrounds, Guiton, *supra*, at 54, and when medical schools

actively promote student engagement and perspective-sharing across diverse backgrounds. Saha et al., *supra*, at 1141.

It is a reality that "minority patients tend to receive better interpersonal care from practitioners of their own race or ethnicity." HHS, Bureau of Health Professionals, *The Rationale for Diversity in the Health Professions: A Review of the Evidence* 3 (2006) (bhpr.hrsa.gov/healthworkforce/reports/diversityreviewevidence.pdf) (reviewing 55 publicly available studies addressing diversity in health care). One goal of valuing diversity in medical education is to change that reality. One contributor to this disparity is unconscious bias on the part of physicians. Studies have shown that this bias exists and negatively impacts clinical decision making, which leads to negative treatment decisions and outcomes.[2] There is also a connection between the unconscious bias of the physician and the patient's negative response to that behavior. *See* Lisa A. Cooper, et al., *The Associations of Clinicians' Implicit*

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[2] *See*, *e.g.*, Santry & Wren, *supra*; A.R. Green et al., *Implicit Bias Among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 J. Gen. Internal Med. 1231 (2007); Janice A. Sabin et al., *Physicians' Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender*, 20 J. Health Care for Poor & Underserved 896 (2009); L.M. Bogart et al., *Factors Influencing Physicians' Judgments of Adherence and Treatment Decisions for Patients with HIV Disease*, 21 Med. Decision Making 28 (2001); Michelle van Ryn et al., *Physicians' Perceptions of Patients' Social and Behavioral Characteristics and Race Disparities in Treatment Recommendations for Men with Coronary Artery Disease*, 96 Am. J. Pub. Health 351 (2006); Michelle van Ryn & Jane Burke, *The Effect of Patient Race and Socio-Economic Status on Physicians' Perceptions of Patients*, 50 Soc. Sci. & Med. 813 (2000).

*Attitudes about Race with Medical Visit Communication and Patient Ratings of Interpersonal Care*, 102 Am. J. Pub. Health 979 (2012). And it has been shown that patients are more likely to make appointments and adhere to a physician's prescribed treatment when the physician and patient share characteristics such as age, sex, education, and race. *See* R.L. Thornton, et al., *Patient-Physician Social Concordance, Medical Visit Communication and Patients' Perceptions of Health Care Quality*, 85 Patient Educ. & Counseling 201 (2011).

Only by producing a workforce of health care professionals who are well-adapted to working in a diverse environment, with patients from all backgrounds, can health professional schools hope to alleviate some of these disparities in patient care.

Increased exposure to diverse perspectives may also increase an individual's ability to understand, accept, and ultimately value disparate viewpoints. Research among college students indicates that this ability can increase after engaging in even a single discussion with an individual expressing a minority viewpoint. Anthony Lising Antonio et al., *Effects of Racial Diversity on Complex Thinking in College Students*, 15 Psychol. Sci. 507 (2004). And prolonged exposure to diverse viewpoints may have a cumulatively stronger impact on complex thinking skills. *Id.* at 509. For a physician or other health professional attempting to properly diagnose and design treatment plans for patients with different cultures, backgrounds, belief systems, and support networks, the ability to consider and integrate other perspectives is an essential skill.

In turn, the ability to work with individuals having diverse perspectives can improve outcomes. Studies

have indicated that groups of people with diverse backgrounds and ways of viewing the world outperform groups of people who have similar backgrounds and perspectives, even when the latter group is composed of those deemed to be the best individual performers. *See* Scott E. Page, *The Difference: How the Power of Diversity Creates Better Groups, Firms, Schools, and Societies* (2007). In the health care arena, "[d]iverse teams working together and capitalizing on individuality and distinct perspectives outperform homogenous teams. This is particularly true when teams address complex problems, such as those that characterize biomedical and behavioral research, technology, and health." NIH, *Draft Report of the Advisory Committee to the Director Working Group on Diversity in the Biomedical Research Workforce* ("*NIH Draft Report*") at 11 (2012) (acd.od.nih.gov/Diversity%20in%20the%20Biomedical%20Research%20Workforce%20Report.pdf) (citing L. Hong & S.E. Page, *Groups of Diverse Problem Solvers Can Outperform Groups of High-Ability Problem Solvers*, 101 Proc. Nat'l Acad. Sci. USA 16385 (2004) and Valerie I. Sessa & Jodi J. Taylor, *Executive Selection: Strategies for Success* (Ctr. for Creative Leadership 2000)).

Recognition of this phenomenon has led to fundamental changes in medical education. To capture the proven benefits of team-based, patient-centered care using a team of professionals with diverse perspectives, medical schools increasingly require students to work in teams and train alongside students in other fields. This inter-professional education can help future health care providers learn to work in a collaborative environment that considers all aspects of health, lifestyle, and background to provide the

best care for the patient. In a similar fashion, medical school students whose classmates represent diverse perspectives will be more prepared and capable of working collaboratively alongside others with diverse perspectives. "A workforce that brings the full power of diversity to pursue biomedical and behavioral research problems that address the needs of underrepresented racial and ethnic minorities is an important component of reducing these health inequities." *NIH Draft Report*, *supra*, at 11 (citing D.M. Stoff et al., *Introduction: The Case for Diversity in Research on Mental Health and HIV/AIDS*, 99 Am. J. Pub. Health S8 (Supp. 1 2009)). As indicated by a former Surgeon General, "a diverse team of researchers will be more likely to ask and pursue the most appropriate questions in the most appropriate manner—whether in basic and clinical research, or in health services and behavioral research." *Id.* (citing David Satcher, *Embracing Culture, Enhancing Diversity, and Strengthening Research*, 99 Am. J. Pub. Health S4 (Supp. 1 2009)).

In order to select candidates who embody these diverse viewpoints, medical schools consider factors that can include rural or urban backgrounds, bachelor's degrees in the sciences or liberal arts, unusual life experiences or journeys, and disparate racial and economic backgrounds, among others. A richly diverse class can contribute to a dynamic, multi-dimensional educational environment where classroom and study-group discussions add insight and texture to course materials.

These benefits of diversity in health professional education have been recognized by Congress, *see* 42 U.S.C. § 300u-6 note ("diversity in the faculty and student body of health professions schools enhances

the quality of education for all students attending the schools") (Congressional finding (12)), and by students, *e.g.*, Dean K. Whitla et al., *Educational Benefits of Diversity in Medical School*, 78 Acad. Med. 460, 466 (2003) (medical school students overwhelmingly report that contacts with diverse peers greatly enhanced their educational experience). "[I]t is not too much to say that the 'nation's future depends upon leaders trained through wide exposure' to the ideas and mores of students as diverse as this Nation of many peoples." *Bakke*, 438 U.S. at 314 (Powell, J.) (citation omitted).

Efforts to promote the inclusion of racial and ethnic minorities are vital to the institutional goals of medical and other health professional schools. While diversity in medical and other health professional school admissions is not itself an end goal, it is an essential mechanism for helping to produce a culturally aware workforce of future health care professionals. A diverse student body can have a lasting impact on the way that physicians and other health care professionals will serve the public in the future. As a consequence, amici have concluded that greater diversity in the educational environment is essential to addressing the health care needs of an increasingly diverse population. This educational judgment warrants deference. *See Grutter*, 539 U.S. at 328 ("The Law School's educational judgment that such diversity is essential to its educational mission is one to which we defer," in keeping with the Court's "tradition of giving a degree of deference to a university's academic decisions, within constitutionally prescribed limits").

The bodies that are responsible for accrediting medical schools likewise recognize the important role

that student diversity plays in the effective delivery of health care. In its *Standards for Accreditation*, the Liaison Committee on Medical Education ("LCME") affirms that "aspiring future physicians will be best prepared for medical practice in a diverse society if they learn in an environment characterized by, and supportive of, diversity and inclusion." LCME, *Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree* ("*Standards for Accreditation*") at 5 (2012) (www.lcme.org/functions.pdf) (requirement IS-16). As of 2009, an accredited medical school in the United States "must have policies and practices to achieve appropriate diversity among its students, faculty, staff, and other members of its academic community, and must engage in ongoing, systematic, and focused efforts to attract and retain students, faculty, staff, and others from demographically diverse backgrounds." *Id.* Importantly, however, the *Standards for Accreditation* do not define diversity, but instead defer to each individual school for what types and levels of diversity are best suited to achieve the mission and goals of the institution.

Other bodies responsible for the accreditation of health professional programs have adopted similar standards. The Commission on Osteopathic College Accreditation advises: "A diverse student body provides the richness necessary for osteopathic medical education. A [school] should make every effort to recruit students from a diverse background to foster that richness while meeting its mission and objectives." Commission on Osteopathic College Accreditation, *Accreditation of Colleges of Osteopathic Medicine: COM Accreditation Standards*

*and Procedures* 21 (2012) (www.osteopathic.org/inside-aoa/accreditation) (guideline to Rule 5.3.2).

The Commission on Dental Accreditation has similarly recognized that "the demographics of our society are changing," and that "[d]iversity in education is essential to academic excellence." Commission on Dental Accreditation, *Accreditation Standards for Dental Education Programs* 9, 13 (2010) (www.ada.org/sections/educationAndCareers/pdfs/predoc_2013.pdf). Echoing the importance of cultural competence in the medical profession, the most recent standards emphasize the role of classroom diversity in achieving this goal:

> A significant amount of learning occurs through informal interactions among individuals who are of different races, ethnicities, religions, and backgrounds; come from cities, rural areas and from various geographic regions; and have a wide variety of interests, talents, and perspectives. These interactions allow students to directly and indirectly learn from their differences, and to stimulate one another to reexamine even their most deeply held assumptions about themselves and their world. Cultural competence cannot be effectively acquired in a relatively homogenous environment. Programs must create an environment that ensures an in-depth exchange of ideas and beliefs across gender, racial, ethnic, cultural and socioeconomic lines.

*Id.* at 13.

In 2004, following the 2002 Institute of Medicine Report entitled *Unequal Treatment: Confronting the*

*Racial and Ethnic Disparities in Health Care*, the American Medical Association ("AMA"), the National Medical Association, and the National Hispanic Medical Association established the Commission to End Health Care Disparities ("CEHCD"). The CEHCD focuses on four major areas: (1) educating and training professionals on ethnic disparities and cultural competencies; (2) increasing workforce diversity in medical and allied health care professions; (3) advancing policy and advocacy initiatives that improve the quality of care provided to minority and multicultural populations and health outcomes; and (4) improving the collection of data and research in order to identify and eliminate health care disparities. *See* CEHCD, *Bylaws* (2012) (www.ama-assn.org/resources/doc/public-health/cehcd-bylaws.pdf).

None of these organizations has promoted a specific form of diversity, and yet all emphasize the vital role that it plays in educating and training health care professionals. Prohibiting medical educators from valuing and achieving diversity would harm both students and the broader society that they are being trained to serve.

## II. MEDICAL SCHOOLS HAVE LONG RELIED ON HOLISTIC REVIEW FOR ADMISSIONS DECISIONS.

In order to look beyond grades and test scores during the admissions process, most medical schools have adopted a holistic review process similar to that upheld by this Court in *Grutter*. Holistic review is a flexible, highly-individualized consideration of the multiple ways in which medical school applicants can demonstrate merit. "Under a holistic review framework, candidates are evaluated by criteria that

are institution-specific, broad-based, and mission-driven and that are applied equitably across the entire candidate pool." *Integrating Holistic Review Practices*, *supra*, at ix. Since well before the *Grutter* decision, most medical schools have used at least some form of highly-individualized review in the admissions process that considers the many dimensions of merit, and potential contributions to the learning environment, of each candidate.

### A. Medical Schools Have A History Of Highly Individualized Admissions Practices.

The qualities that contribute to a successful health care professional are impossible to measure with grades and test scores alone. "Medical educators agree that success in medical school requires more than academic competence; it also requires integrity, altruism, self-management, interpersonal and team-work skills, among other characteristics." Dana Dunleavy et al., *Medical School Admissions: More than Grades and Test Scores*, 11 Analysis In Brief, No. 6, at 1 (Sept. 2011). To assess these qualities, medical schools have a long history of highly individualized admissions processes, including personal pre-admission interviews for every accepted applicant.

Although these processes vary with the educational mission and goals of each school, all medical schools consider a range of non-academic factors. *Id.* Medical schools have never exclusively relied on numerical criteria to select their student bodies. *See* Filomeno Maldonado, *Rethinking the Admissions Process: Evaluation Techniques That Promote Inclusiveness in Admissions Decisions*, in *The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in Health Care Professions* at 305-07 (Inst. of

Medicine 2001). While undergraduate GPA and MCAT scores are usually high on the list of considerations in determining which applicants to interview, medical schools rank the personal interviews and letters of recommendation as the most important considerations in making final acceptance decisions. Dunleavy, *supra*, at 2. In fact, between 2009 and 2011, 8.5% of applicants with the highest combined GPAs and MCAT scores were *rejected* by *all* of the medical schools to which they applied. *See* AAMC, *MCAT and GPA Grid for Applicants and Acceptees to U.S. Medical Schools*, *2009-2011* (2011) (www.aamc.org/download/270906/data/table24-mcat pagridall0911.pdf) (Table 24).

Holistic review precludes any single criterion from becoming the uniform deciding factor for interviewing and selecting candidates for admission. Serious consideration is afforded to the ways in which each applicant might uniquely contribute to a diverse educational environment. Each candidate is able to communicate his or her potential as more than a set of numbers, and, through holistic review, medical schools are able to consider these factors in light of the institutional goals for the classroom, clinical practice, and biomedical research. *See Integrating Holistic Review Practices*, *supra*, at x. This holistic consideration of applicants is precisely the reason that individual interviews are so vital to the medical school admissions process.

For some medical schools, the range of factors considered during holistic review may include race, ethnicity, and gender. However, these factors are only considered to the extent necessary to achieve clearly articulated mission-driven benefits. *Id.* at 6. To the extent that race is considered, it is never considered

in isolation. Instead, it is considered flexibly as just one of the many characteristics and pertinent elements of each individual's background. Characteristics that make an individual particularly well-suited for the medical profession, such as resilience or the ability to overcome challenges, may in some cases be intertwined with an individual's race or ethnicity. When candidates have overcome great race-related challenges, obscuring or denying the realities of these challenges will hinder a full appreciation of the applicant's potential contributions.

For most schools, there is no substitute for the consideration of an individual's racial identity and ethnic background as part of holistic review intended to ensure that health professionals are educated in a diverse environment. As the Court indicated in *Grutter*, "percentage plans," such as the one used by respondent for undergraduate admissions, do not translate to the professional school environment. *See Grutter*, 539 U.S. at 340 ("The United States does not * * * explain how such plans could work for graduate and professional schools. Moreover, even assuming such plans are race-neutral, they may preclude the university from conducting the individualized assessments necessary to assemble a student body that is not just racially diverse, but diverse along all the qualities valued by the university."). Most medical schools draw from a nationwide (and often worldwide) applicant pool that makes it impossible to make simple comparisons based on grade point averages. And as noted, such comparisons do not begin to capture the range of qualities that schools have always considered.

Moreover, medical schools have expressly relied on this Court's pronouncements in crafting their holistic

review procedures. After the Court's decision in *Grutter*, the AAMC convened an Advisory Committee on Holistic Review, a constituent working group representing a number of health disciplines, to address how to increase diversity among health professional students in alignment with the framework upheld in *Grutter*. The Advisory Committee began developing tools and resources, such as the *Roadmap* guidance documents discussed above, that medical schools could adopt or adapt to create and sustain student diversity through the use of holistic review in the admissions process. Using these tools, the AAMC has conducted cross-country workshops with dozens of medical schools each year, and in 2012 will expand into Osteopathic schools. The AAMC's commitment to assisting medical schools in crafting institution-specific diversity policies in the context of a legally-sound holistic review process is ongoing, with two additional publications anticipated in 2012: a white paper on institutional alignment and a third *Roadmap* guidance document on self-evaluation of admissions practices and policies.

Medical schools do not use the Court's approved holistic review framework as a substitute for merit-based consideration of medical school applicants. Rather, it is a process through which medical schools are better able to appreciate the individual merits of each candidate to be a successful student and, ultimately, physician. Indeed, as a group, underrepresented minority students perform extremely well in medical school, with 95.5% graduating and 98% passing the first medical licensing examination. *See* AAMC, *Using MCAT Data in Medical Student Selection: A Supplement to*

*the March 2012 Report with Results for Racial and Ethnic Groups* 7-14 (2012).

### B. Although Other Initiatives Have Shown Some Success, It Remains Necessary For Medical Schools To Consider Applicants' Full Backgrounds In Order To Achieve The Schools' Educational Goals.

In accordance with the requirements of narrow tailoring, direct consideration of race is not intended to continue indefinitely. Medical schools are implementing a host of initiatives outside of the admissions context to help achieve a diverse and culturally-competent student body and physician workforce. Those initiatives have had some success in increasing the diversity of the medical school applicant pool. But they are not the complete answer. In order to discharge their obligations to produce well-trained health professionals who are prepared to serve all of society, many medical schools continue to find it necessary to consider an applicant's entire background, including race or ethnicity as one factor among many.

As recognized by the LCME, medical schools must "recognize [their] collective responsibility for contributing to the diversity of the profession as a whole." *Standards for Accreditation*, *supra*, at 17 (requirement MS-8). In carrying out this responsibility, schools are encouraged to "make admission to medical education programs more accessible to potential applicants of diverse backgrounds," including through "the development and institutionalization of pipeline programs, collaborations with institutions and organizations that serve students from disadvantaged backgrounds, community service activities that heighten awareness of

and interest in the profession, and academic enrichment programs for applicants who may not have taken traditional pre-medical coursework." *Id.*

"Pipeline" programs, which seek to encourage underrepresented minorities to pursue a medical education at a young age, have had promising preliminary results. A study of one such program, the Stanford Medical Youth Science Program, indicated that 52% of program participants had either already completed or were currently enrolled in medical or graduate school. *See* Marilyn A. Winkleby, *The Stanford Medical Youth Science Program: 18 Years of a Biomedical Program for Low-Income High School Students*, 82 Acad. Med. 139, 143 (2007). Programs of the University of California designed to help individuals displaying predictors of future service to vulnerable communities enroll in medical school helped participants not only become physicians but also reach the communities that they aspire to serve. Kevin Grumbach & Eric Chen, *Effectiveness of University of California Postbaccalaureate Premedical Programs in Increasing Medical School Matriculation for Minority and Disadvantaged Students*, 296 JAMA 1079, 1082-85 (2006). Another recent study of similar programs concluded that among students matriculating into medical school, "postbaccalaureate premedical program participants were demographically diverse and, at medical school graduation, were more likely than nonparticipants to plan to practice in underserved areas." Dorothy A. Andriole & Donna B. Jeffe, *Characteristics of Medical School Matriculants Who Participated in Postbaccalaureate Premedical Programs*, 86 Acad. Med. 201, 201 (2011). Similarly, the AMA developed the *Doctors Back to School*

*Program* in 2002 to enable minority physicians to visit with elementary, middle, and high schools nationwide and promote careers in medicine. *See* AMA, *Doctors Back to School* (www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/minority-affairs-section/doctors-back-school.page)

Medical schools have also invested in recruitment and outreach strategies that are designed to increase the number of underrepresented minority applicants. For example, the University of Chicago Pritzker School of Medicine found that having a focus in the medical school curriculum on health disparities among underrepresented minorities correlated with a significant increase in accepted underrepresented minorities deciding to matriculate. Monica B. Vela et al., *Improving Underrepresented Minority Medical Student Recruitment with Health Disparities Curriculum*, 25 J. Gen. Intern. Med. S82, S83-85 (2010). At the University of New Mexico School of Medicine, initiatives to target recruitment and increase academic, personal, and cultural support for Native American students, through efforts such as creating a Native American student center, contributed to increases in the number of Native American matriculants. *See Native American Enrollment Doubles at School of Medicine*, UNM Today (July 22, 2009) (www.unm.edu/~market/cgi-bin/archives/2009_07.html).

Systemic changes are also being made in the medical education system to address concerns about cultural competence in health care. For example, the AAMC and the Association of Schools of Public Health ("ASPH") have published joint recommendations for training medical and public health students to become more culturally competent

practitioners. *See* AAMC & ASPH, *Cultural Competence Education for Students in Medicine and Public Health* (July 2012) (members.aamc.org/eweb/upload/Cultural%20Competence%20Education_revisedl.pdf). AAMC has also worked to develop a new MCAT exam to be introduced in 2015, designed in part to measure how well an applicant understands the cultural, social, and socio-economic differences that can influence health.

While many of these programs and efforts are helpful, on their own they are insufficient. Due to a multitude of factors outside of medical schools' influence or control, including economic forces, the past decade has not shown an overall increase in the percentages of underrepresented minorities nationwide that apply to medical school. *See* AAMC, *Race and Ethnicity Responses of Applicants to U.S. Medical Schools, 2002-2011* (2011) (www.aamc.org/download/161198/data/table13.pdf) (Table 13). That disparity cannot be rectified by assessing applicants based on proxy criteria such as economic disadvantage. For example, simply focusing on statistical information that correlates with disadvantage—such as low socio-economic status—will in all likelihood reduce rather than increase the number of underrepresented minority applicants accepted for admission. Ann Steinecke et al., *Race-Neutral Admission Approaches: Challenges and Opportunities for Medical Schools*, 82 Acad. Med. 117, 123 (2007); William G. Bowen & Derek Bok, *The Shape of the River* 270-71 (1998).

Medical educators continue to find that a deliberate focus on fostering diversity in medical education is essential if medical schools are to fulfill their responsibility to effectively serve all of society. It is

hoped that such actions will no longer be necessary in the future, but that future has not yet arrived.

## III. ALTERING *GRUTTER* WOULD DISRUPT ADMISSIONS PRACTICES CRAFTED IN RELIANCE UPON THE COURT'S PRECEDENTS.

Petitioner invites the Court to either overrule the central holding in *Grutter* or to "clarify" that holding by removing the deference to school administrators in determining how best to achieve the compelling interest of fostering educational diversity. *See* Pet. Br. 53-57. The Court should reject that invitation. For more than thirty years, the Nation's medical schools have utilized the kind of holistic admissions process approved by the Court's holdings in *Bakke* and *Grutter*. In the schools' expert judgments, such practices are necessary to train physicians and other leaders in the health professions who can effectively serve an increasingly diverse society. Administrators have faithfully abided by the Court's guidance, and amici urge the Court not to disrupt that reliance by withdrawing its imprimatur from those longstanding practices.

The Court's commitment to *stare decisis* "promotes the evenhanded, predictable, and consistent development of legal principles, fosters reliance on judicial decisions, and contributes to the actual and perceived integrity of the judicial process." *Payne* v. *Tennessee*, 501 U.S. 808, 827 (1991). "Indeed, the very concept of the rule of law underlying our own Constitution requires such continuity over time that a respect for precedent is, by definition, indispensable." *Planned Parenthood of SE Pa.* v. *Casey*, 505 U.S. 833, 854 (1992) (citing Lewis F.

Powell, Jr., *Stare Decisis and Judicial Restraint*, 1991 J. Sup. Ct. Hist. 13, 16 (1991)).

Accordingly, the Court will adhere to precedent except in the rare circumstances where a prior rule has proven "outdated, ill-founded, unworkable, or otherwise legitimately vulnerable to serious reconsideration." *Vasquez* v. *Hillery*, 474 U.S. 254, 266 (1986). The Court looks to whether an established rule "has proven to be intolerable simply in defying practical workability," whether it "is subject to a kind of reliance that would lend a special hardship to the consequences of overruling and add inequity to the cost of repudiation," whether it is "no more than a remnant of abandoned doctrine," and whether changed facts "have robbed the old rule of significant application or justification." *Casey*, 505 U.S. at 854-55 (citations omitted). Finally, the Court requires "the most compelling reason to reexamine a watershed decision"—and there is little question that *Grutter* was such a decision—because to do otherwise "would subvert the Court's legitimacy beyond any serious question." *Id*. at 867.

None of these considerations warrants departing from *Grutter*. Far from "defying practical workability," the holistic admissions process approved in *Grutter* and *Bakke* continues to be the predominant mode of decision making employed by universities and graduate schools across the Nation. Those schools, moreover, have expressly relied on this Court's precedents in doing so. As the Court remarked in *Grutter*, "[p]ublic and private universities across the Nation have modeled their own admissions programs on Justice Powell's views." *Grutter*, 539 U.S. at 307. That reliance has only grown in the nearly ten years since the full Court endorsed Justice

Powell's reasoning. *See supra* at 26. And there are no new facts that "have robbed [*Grutter*'s] rule of significant application or justification." *Casey*, 505 U.S. at 854-55. Quite the opposite, the need for educators to value diversity in education has increased as our Nation has become more diverse.

It is petitioner's approach, not the *Grutter* rule, that is unworkable and that would have deleterious consequences if applied in the medical school context. In petitioner's view, judges and juries must continually scrutinize every admissions program to determine whether consideration of race or ethnicity is unnecessary because the school is "already enrolling [a] critical mass of minority students" without regard to that consideration. Pet. Br. 20. Under that rule, any use of race or ethnicity as part of a holistic review process is unnecessary, and thus unconstitutional, whenever a court determines that a critical mass of diverse students can be achieved without it. Under *Grutter*, by contrast, the "concept of critical mass is defined by reference to the educational benefits that diversity is designed to produce" and the Court will defer to a school's "assessment that diversity will, in fact, yield educational benefits." *Grutter*, 539 U.S. at 328, 330. Contrary to petitioner's contention that *Grutter* requires courts to examine any consideration of race under an "absolute necessity" standard, Pet. Br. 51, the Court should instead continue to defer to the judgment of expert educators, provided that they engage in a "serious, good faith consideration of workable race-neutral alternatives." *Id.* at 339.

It is impossible for administrators to know in advance whether a judge or jury would find that the consideration of race or ethnicity in a particular

admissions decision meets petitioner's test of "absolute necessity." It is difficult, if not impossible, to insulate consideration of an applicant's race or ethnicity from consideration of the rest of that individual's background. Where an admissions process includes reliance on personal statements, for example, ignoring race and ethnicity "might not even be possible," since "to read the file in a 'colorblind' way, the admissions officer would likely have to ignore highly relevant information, without which the applicant's personal statement might literally not make sense." Devon W. Carbado & Cheryl I. Harris, *The New Racial Preferences*, 96 Cal. L. Rev. 1139, 1146-47, 1149 (2008). Similarly, requiring applicants to exclude any references to their race or ethnicity "create[s] an incentive for applicants to suppress their racial identity and to adopt the position that race does not matter in their lives," which "is likely to be particularly costly to applicants for whom race is a central part of their social experience and sense of identity." *Id.* at 1148.

The problem is compounded for medical and other health professional schools. Unlike most undergraduate institutions, medical and other health professional schools have always considered and highly value personal interviews in order to learn what the applicant's background would contribute to a culturally competent workforce. Requiring such consideration to proceed under the constant threat of judicial second-guessing would result in an admissions process that is very different from the one that has existed throughout modern history, and that would fail to meet the schools' obligations to both students and society at large. Removing the ability of medical schools to consider applicants' race

and ethnicity as one of many personal attributes would undermine their ability to assess the entirety of each individual's background, thus frustrating the goal of best serving the public's health. At a time when our Nation is becoming more diverse, and health disparities remain so stark, constraining a medical school's ability to consider a student's entire background would negatively impact not only the classroom, but also patients, who would be deprived of a pipeline of physicians better equipped through personal experience and a diverse learning environment to provide the treatment and discover the cures for diseases that disproportionately impact minority populations.

Holistic review in medical school admissions is not a static concept. Rather, continuously "[e]valuating the effectiveness of admission policies, processes, and criteria in producing outcomes that reflect a medical school's mission is a core element of holistic review." *Integrating Holistic Review Practices*, *supra*, at 21. In furtherance of that principle, medical schools constantly re-evaluate their admissions processes to align them with the fundamental objectives of producing physicians of the highest caliber who can meet the health needs of the entire population. Given the persistence of health disparities among minority communities and the unconscious bias that contributes to that problem, amici strongly believe that it remains necessary in 2012 for institutions to continue to take action to ensure diversity in the admissions process. Amici believe that it would be a grave mistake for this Court to upset decades of precedent by precluding or significantly reducing the ability of expert medical educators to ensure that the next generation of physicians and other health

professionals is educated and trained in an environment that will prepare them to address the Nation's critical health needs.

## CONCLUSION

For the foregoing reasons, and those in respondents' brief, the judgment below should be affirmed.

Respectfully submitted,

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# ADDENDUM

## AMICI CURIAE

**Association of American Medical Colleges**—represents all 138 accredited U.S. medical schools, nearly 400 teaching hospitals and health systems, and 90 academic societies.

**American Academy of Family Physicians**—represents over 100,000 physicians, residents and medical students.

**American Academy of Pediatrics**—represents 62,000 primary care pediatricians, pediatric medical subspecialists, and surgical specialists who are committed to the attainment of optimal physical, mental and social health and well-being for all infants, children, adolescents, and young adults.

**American Academy of Physician Assistants**—represents over 97,000 physician assistants and physician assistant students.

**American Association of Colleges of Nursing**—represents 700 institutions offering university and four-year college education programs in nursing.

**American Association of Colleges of Osteopathic Medicine**—represents the Nation's 29 osteopathic medical schools, offering instruction at 37 locations in 28 states. Osteopathic medical schools currently educate more than 20 percent of all U.S. medical students.

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

**American College of Physicians**—represents 115,000 internal medicine physicians and medical students.

**American Dental Association**—represents the interests of over 156,000 ADA members from all 50 states, the District of Columbia and Puerto Rico.

**American Dental Education Association**—represents 65 U.S. dental schools and 10 Canadian dental schools.

**American Medical Association**—the largest professional association of physicians, residents and medical students in the United States.

**American Medical Student Association**—represents 32,000 physicians-in-training.

**American Nurses Association**— represents the interests of 3.1 million registered nurses, has more than 140,000 members through both state associations and individual membership, and has 30 national organizational affiliates that collectively represent approximately 300,000 RNs in specialty areas.

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

**American Public Health Association**— the oldest and most diverse organization of public health professionals in the world representing a broad array of health providers, educators, environmentalists, policy-makers and health officials at all levels working both within and outside governmental organizations and educational institutions.

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

**Association of Academic Health Centers**—represents more than 100 institutions, including the Nation's primary resources for education in the

health professions, biomedical and health services research, and many aspects of patient care.

**Association of American Indian Physicians**—represents 368 American Indian/Alaska Native ("AI/AN") physicians dedicated to improving the health of AI/AN people and the recruitment and retention of AI/AN students into health careers.

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

**Association of Schools of Allied Health Professions**—represents 115 institutions which have a wide variety of allied health programs.

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

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

**National Association of Hispanic-Serving Health Professions Schools, Inc.**—represents 21 medical schools and 7 public health schools to improve the health of Hispanics through academic development, research initiatives, and training.

**National Hispanic Medical Association**—represents the interests and concerns of 45,000 licensed physicians committed to the mission to improve the health of Hispanic populations with affiliated Hispanic medical societies, resident and

medical student organizations and other public and private partners.

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

**National Medical Fellowships, Inc.**— provides scholarships for underrepresented minorities in medicine and the health professions.

**Physician Assistant Education Association**—represents 162 of the Nation's accredited physician assistant educational programs.

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

**Student National Medical Association**—represents more than 6,000 medical students, pre-medical students, residents, and physicians.

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