COMMENTARY

Nullifying Affirmative Action and Its Impact on the Pulmonary and Critical Care Medicine Workforce

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In June 2023, the Supreme Court of the United States (SCOTUS) overturned affirmative action in higher education. This decision undermines a two-decade long precedent in which SCOTUS determined that consideration by an admissions committee of whether a candidate is from an "underrepresented minority group," among other variables, did not violate the Equal Protection Clause of the 14th Amendment. However, the current makeup of SCOTUS with six Republican-nominated justices and three Democratic-nominated justices has led to a change in opinion and ideology. As practicing pulmonary and critical care medicine (PCCM) physicians and clinician educators, we find the recent verdict a significant failing with major adverse consequences. Some studies have suggested that increasing the availability of primary care physicians to minoritized populations is associated with improved outcomes, and some studies have identified that a diverse healthcare workforce itself is associated with improved medical outcomes (1). As such, medical institutions should develop comprehensive strategies to support and recruit racially underrepresented trainees. The Association of American Medical Colleges defines people "underrepresented in medicine" (URM) as "those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population."

There has been a long history of systemic racism in medical education, which will likely be exacerbated by the recent SCOTUS ruling. To fully envision the future impact of *Students for Fair Admissions Inc v. President and Fellows of Harvard*

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College/University of North Carolina (600 U.S. 181), we must examine the past. After the Union victory in the Civil War, the 14th amendment granted Black Americans full citizenship and protections; however, the reconstruction era fueled racial segregation and codified the mistreatment of Black individuals via "Jim Crow" laws. In 1896, SCOTUS set the precedent for "separate but equal" treatment of Black Americans in *Plessy v. Ferguson* (163 U.S. 537) when a Black man tried to sit in a delegated Whites-only railway car (2). This verdict translated to inequity in all domains of daily life, including inferior education for Black children, because separate was never truly equal. Some states required separate sets of textbooks for White and Black schools, and some states did not even allow these books to be stored in the same place (3).

Racial segregation continued to grow. The Flexner report, published in 1910 with a stated goal of evaluating standards for U.S. medical schools, used basic science training as a prerequisite for producing clinicians, which closed all but two of the historically Black medical schools, disproportionately affecting Black medical students. The report sought closure of these schools without clear recommendations for how to meet the needs of the community except to advocate for segregated care. Flexner believed that the remaining Black medical schools should train Black physicians to treat (only) Black patients to limit a "potential source of infection and contagion" to the White population (4). This report, written with a racist lens, has quantifiably shortchanged the nation of thousands of Black physicians (5).

The debates over segregated education culminated in the historic 1954 decision by the unanimous SCOTUS ruling in *Brown v. Board of Education* (349 U.S. 294) that "separate educational facilities are inherently unequal" and unconstitutional (6). This sparked the beginning of the civil rights era, during which President Kennedy popularized the term "affirmative action" (in regard to equal employment) and the Civil Rights Act of 1964 was passed (7). Coming upon the 70th anniversary of the landmark *Brown v. Board of Education* ruling, we find the verdict in *Students for Fair Admissions Inc v. President and Fellows of Harvard College/University of North Carolina* a significant failing and evidence of continued ramifications of judicial discrimination.

After the Civil Rights Act of 1964 and the assassination of Rev. Martin Luther King, many universities began to incorporate race in their arbitration processes to diversify their student body. However, affirmative action quickly came under attack with challenges to race-conscious admissions in medical schools. In 1978, a White respondent filed a claim that he was denied admission to the University of California, Davis medical school because of his race and claimed this violated the Equal Protection Clause of the 14th Amendment and Title VI of the Civil Rights Act (*1978 Regents of the University of California v. Bakke*, 438 U.S. 265) (8). SCOTUS ordered admission for the respondent and voided the special admissions program that guaranteed a quota of students to be admitted from disadvantaged backgrounds. This case did, however, uphold affirmative action, stating that race could be one of several factors used in an institution's admission policies. This court further acknowledged that "the purpose of overcoming substantial, chronic minority underrepresentation in the medical profession is sufficiently important to justify petitioner's remedial use of race" (8).

This verdict became the legal basis for affirmative action; however, litigation persisted. In 1995, affirmative action was

overturned in all University of California campuses when Proposition 209 was enacted. This significantly reduced, by an estimated 12%, the admission of students from URM racial groups at California state schools, including their medical schools (9, 10). Other states followed suit, and affirmative action bans led to drops in medical school admissions for URM applicants (11). In fact, in 2015, the American Association of Medical Colleges reported that that there were more Black men applying and attending medical school in 1978 than in 2014 (12).

In its recent opinion, SCOTUS does not address the potential repercussions of their decision. It considered numerical tracking of race to be "racial balancing" and deemed the racial categories "imprecise" and "arbitrary." Race is a social construct, and, as such, we agree that these categories are in fact arbitrary; however, omission of a race variable from class data will obfuscate any reliable means of observing trends in the racial diversity of the future PCCM workforce. Even before Proposition 209, with the support of affirmative action policies, there have been fewer URM fellows in critical care medicine than in other specialties (13), and, despite diversity accreditation standards that improved representation of URM candidates in medicine (14), there remains a disproportionate decline in URM candidates in the PCCM pipeline (15). It is our opinion that omission of a race variable from class data has a greater likelihood of drifting to a less racially diverse trainee pool.

Although fellow recruitment is a hiring practice covered under Title VII as opposed to school admissions under Title VI, program directors would be wise to consider this SCOTUS decision in the context of their recruitment practices. In response to this decision, schools and training programs should incorporate a holistic admissions process to evaluate a wide range of student attributes that might predict success. SCOTUS opines that schools may regard how race has cultivated specific attributes and ambitions for the applicants but does not offer how to assess this. It writes that when evaluating an applicant, the admissions committees can consider only "how race affected his or her life, be it through discrimination, inspiration or otherwise" (16). There are no appropriate means to capture how racism affects a student's experience. Students who have faced hardship should not have to share a trauma narrative that is judged for its merit as a racial struggle by the admissions committee (17). President Biden issued a statement encouraging schools to assess financial background and personal experiences in weighing candidates (18). Although there is significant intersectionality between race and socioeconomic factors, conflating financial hardship with racism is not accurate and invalidates how systemic racism affects people from URM racial groups, particularly in the education process. We posit that applicants might be asked to discuss their identity and how it influences their career path or describe how they believe they can advance the diversity, equity, and inclusive values of the fellowship program. Still, the effects of the 2023 verdict will likely aggravate the disparities in the PCCM workforce.

Some may argue that the rise of Barack Obama to the presidency may signal that the United States has risen to a "postracial society" and thus that such a change in admission policies was warranted. However, as Justice Jackson, in her dissenting opinion, wrote, "The response is simple: Our country has never been colorblind." This SCOTUS decision perpetuates the myth of

"race-neutral" admissions, which obscures long-standing unequal treatment in higher education and misrepresents policies promoting equity as being racially discriminatory. Taking the 14th amendment out of the context in which it was forged is inappropriate, especially in regard to something as important as educating our future physicians. SCOTUS recognized this in the context of the U.S. military, which was excluded from this ruling because of their "distinct interests." The "educational benefit" of a diverse student body, as described by the previous SCOTUS ruling in 2003 in *Grutter v. Bollinger* (539 U.S. 306) (19), could also represent a similar "distinct interest."

As academic physicians and educators, we should strive for a vibrant, collaborative, and diverse workforce that calls upon collective experience, wisdom, and knowledge in healing our patients, especially those who are disenfranchised. It is disheartening to see history repeat itself and wait for the failures of the past to haunt us today and well into the future. Leaders in medical education have reported on methods and interventions, starting as early as grade school, that may help to nurture and recruit traditionally marginalized physicians into the field (20, 21). This includes early identification and appropriate prehealth advising and mentoring (20), which have been particularly successful in achieving a racially diverse student body in the University of California, Davis in the post–Proposition 209 era. As Dr. Saha writes in their recent editorial, through the dismissal of racial diversity as the desired result of university admissions, there is an opportunity to refocus efforts on equity (22), although execution of this lofty goal will require unrelenting goal setting and active evaluation, which can easily be deprioritized for busy clinicians who are also tasked with navigating the stipulations of this verdict. There are few measures that fellowship programs can enact in isolation to attract a more diverse pool of candidates. Usually, increasing the pipeline requires infrastructure and divisional commitment, such as a mission to diversify the PCCM faculty or an internal medicine residency pathways program. There are specific procedures that can help realize this goal, however, such as implementing holistic review processes during fellowship application cycles, creating an inclusive environment for residents and fellows that involves PCCM-specific mentorship and research opportunities, and even creating "away" in-person or virtual electives for interested URM candidates. Still, the SCOTUS ruling has emboldened state and federal government officials to normalize reverse racism and propose laws to ban diversity, equity, and inclusion efforts, including withholding federal funding to medical schools that are not compliant with the mandate (23–25). At this point, with these new setbacks, doctors must take up the mantle of advocacy to enact legislative change and redouble our efforts to recruit and train a diverse group of PCCM providers.

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