**Nos. 20-1199 & 21-707**

IN THE

# Supreme Court of the United States

STUDENTS FOR FAIR ADMISSIONS, INC.,

*Petitioner*,

v.

PRESIDENT AND FELLOWS OF HARVARD COLLEGE,

*Respondent*.

STUDENTS FOR FAIR ADMISSIONS, INC.,

*Petitioner*,

v.

UNIVERSITY OF NORTH CAROLINA, ET AL.,

*Respondents*.

On Writs of Certiorari
to the United States Courts of Appeals
for the First and Fourth Circuits

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


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## TABLE OF CONTENTS

## TABLE OF AUTHORITIES

TABLE OF AUTHORITIES—Continued

Page(s)

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

Page(s)

TABLE OF AUTHORITIES—Continued

Page(s)

TABLE OF AUTHORITIES—Continued

Page(s)

TABLE OF AUTHORITIES—Continued

Page(s)

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

Page(s)

TABLE OF AUTHORITIES—Continued

Page(s)

TABLE OF AUTHORITIES—Continued

Page(s)

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

Page(s)

TABLE OF AUTHORITIES—Continued

Page(s)

TABLE OF AUTHORITIES—Continued

Page(s)

TABLE OF AUTHORITIES—Continued

Page(s)

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## INTERESTS OF AMICI CURIAE[1]

The Association of American Medical Colleges ("AAMC") is a non-profit educational association

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

whose members include all 156 accredited U.S. medical schools; more than 400 teaching hospitals and health systems; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and their more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

AAMC is joined in this brief by a diverse array of 45 other healthcare organizations interested in the issues presented, including:

Fourteen organizations whose members include schools, residency programs, and other institutions involved in educating and training healthcare providers and administrators: the Accreditation Council for Pharmacy Education; American Association of Colleges of Nursing; American Association of Colleges of Pharmacy; American Association of Colleges of Podiatric Medicine; American Association of Veterinary Medical Colleges; American Dental Education Association; American Institute for Medical and Biological Engineering; Associated Medical Schools of New York; Association of Schools Advancing Health Professions; Association of Schools and Colleges of Optometry; Association of Schools and Programs of Public Health; Association of University Programs in Health Administration; Council on Social Work Education; and Physician Assistant Education Association;

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person other than amici or their counsel made a monetary contribution to this brief's preparation or submission. The parties have consented to the filing of this brief.

Twenty-six organizations whose members include physicians and other healthcare providers: the American Medical Association; American Academy of Child and Adolescent Psychiatry; American Academy of Family Physicians; American Academy of Pediatrics; American Academy of Psychiatry and the Law; American Association for Geriatric Psychiatry; American Association of Directors of Psychiatric Residency Training; American College of Obstetricians and Gynecologists; American College of Physicians; American College of Psychiatrists; American Pediatric Society; American Psychiatric Association; American Public Health Association; American Society of Hematology; American Society of Hispanic Psychiatry; Association of American Colleges of Osteopathic Medicine; Association of American Indian Physicians; Association of Women Psychiatrists; Black Psychiatrists of America, Inc.; Council of Medical Specialty Societies; National Asian American Pacific Islander Mental Health Association; National Council of Asian Pacific Islander Physicians; National Hispanic Medical Association; National Medical Association; Philippine Psychiatrists in America; and Society for Pediatric Research; and

Five organizations representing the interests of medical-school students: the American Medical Student Association; Asian Pacific American Medical Student Association; Latino Medical Student Association; National Medical Fellowships, Inc.; and Student National Medical Association.

## SUMMARY OF THE ARGUMENT

Diversity in the education of the Nation's physicians and other healthcare professionals is a medical imperative. As an overwhelming body of scientific research compiled over decades confirms, diversity

literally saves lives by ensuring that the Nation's increasingly diverse population will be served by healthcare professionals competent to meet its needs. Research confirms that being treated by a racially diverse care team, or by doctors with exposure to diverse professional or educational environments, greatly increases the likelihood of positive medical outcomes, particularly for minority patients.

For example, in controlled studies, Black physicians are far more likely than others to accurately assess Black patients' pain tolerance and prescribe the correct amount of pain medication as a result.[2] And for high-risk Black newborns, having a Black physician is tantamount to a miracle drug: it more than doubles the likelihood that the baby will live.[3] Yet due to the enduring and significant underrepresentation of minorities in the health professions, many minority patients will not receive care from a racially diverse team or from providers who were trained in a diverse environment.

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[2] *See* Kelly M. Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences Between Blacks and Whites*, 113 Proc. Nat'l Acad. Scis. 4296, 4298-30 (2016); Monika K. Goyal et al., *Racial Disparities in Pain Management of Children with Appendicitis in Emergency Departments*, 169 JAMA Pediatr. 996, 998-999 (2015); Karn O. Anderson et al., *Racial and Ethnic Disparities in Pain: Causes and Consequences of Unequal Care*, 10 J. Pain 1187, 1198 (2009); C.S. Cleeland et al., *Pain and Treatment of Pain in Minority Patients With Cancer*, Eastern Cooperative Oncology Group Minority Outpatient Pain Study, 127 Annals Intern. Med. 813, 815 (1997).

[3] Brad N. Greenwood et al., *Physician-Patient Racial Concordance and Disparities in Birthing Mortality for Newborns*, 117 Proc. Nat'l Acad. Scis. No. 35, 21194, at 21195-97 (2020).

These facts present a clear imperative for medical education. It is, of course, neither proper nor possible for all minority patients to be treated by minority healthcare professionals. But medical educators have learned—through both scientific research and years of experience—that health disparities can be minimized when professionals have learned and worked next to colleagues of different racial and ethnic backgrounds in environments that reflect the ever-increasing diversity of the society the profession serves. Thus, diversity in medical education yields better health outcomes not just because minority professionals are often more willing to serve (and often very effective at serving) minority communities, but because ***all*** physicians become better practitioners overall as a result of a diverse working and learning environment.

As the gatekeepers to the medical profession, health-professional schools owe obligations to society at large—not just to their students and applicants. Among those obligations is a responsibility to improve medical care and access thereto for all Americans. The need for such improvements is felt most acutely by minority communities, which generally receive less and lower-quality care than the national average. And given the demonstrated, measurable health benefits of a diverse and diversity-educated medical profession, the Nation's health-professional schools would be shirking those basic obligations if they failed to admit and graduate diverse physicians and other healthcare professionals, and to provide the benefits of a diverse education to all their students.

In *Regents of the University of California* v. *Bakke*, 438 U.S. 265 (1978)—a decision that specifically addressed medical education—the Court approved of these principles, with Justice Powell providing the

deciding rationale. As he explained, "[p]hysicians serve a heterogeneous population," and "[a]n otherwise qualified medical student with a particular background—whether it be ethnic, geographic, culturally advantaged," or otherwise, "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. Twenty-five years later, the Court 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, 323 (2003); *see also id.* at 387 (Kennedy, J., dissenting). And in the *Fisher* cases, the Court reaffirmed *Bakke* yet again. *See Fisher* v. *Univ. of Tex.*, 570 U.S. 297, 303 (2013) ("*Fisher I*"); *Fisher* v. *Univ. of Tex.*, 579 U.S. 365, 387 (2016) ("*Fisher II*").

Justice Powell's words continue to ring true today. In fact, given the Nation's increased—and increasing—diversity, the need to train the next generation of physicians in a diverse educational environment is even more important now, as is the need to graduate medical professionals reflecting the diversity of the society they serve. Studies conclusively establish that when physicians understand more about the diverse cultures and individuality of their patients, medical outcomes improve. Thus, preventing medical educators from continuing to consider diversity in admissions would not merely impoverish the educational experience of all future healthcare professionals; it would literally cost lives and diminish the quality of many others'.

In the decades since *Bakke*, and through *Fisher II*, the Nation's medical schools have been implementing and refining holistic admissions methods of the type this Court has repeatedly approved. In evaluating an applicant's ability to contribute to and benefit from an enriching educational environment, race is considered merely as one of many factors, none of which is dispositive standing alone. Although test scores and grades are a significant barometer of academic achievement, they have never been independently determinative in medical school admissions, which have also always given substantial weight to the individualized interviews that are required of each admitted student. 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 best equipped to serve ***all*** of society.

There is no proven substitute for this individualized, holistic review, and prohibiting it would open a Pandora's box by preventing some applicants from being considered for their full selves and history and thereby limiting medical schools in fulfilling their obligations to society. There is no way to know how non-diverse the healthcare community would become in future years and decades if holistic review were forbidden in medical education, but it is clear that the lives and health of the American public would be gravely diminished. Accordingly, amici urge this Court to take no action that would disrupt the admissions processes the Nation's health-professional schools have carefully crafted in reliance on this Court's longstanding precedents.

## ARGUMENT

### I. DIVERSITY IS VITAL TO HEALTHCARE OUTCOMES AND, THEREFORE, TO THE EDUCATIONAL MISSION OF THE NATION'S MEDICAL SCHOOLS.

#### A. Race-Linked Health Inequities Require Urgent Intervention.

Despite attracting the best medical professionals from around the world, the United States continues to rank shockingly high on certain negative health outcomes compared to other nations. This is likely due in part to the fact that large segments of American society continue to suffer disproportionately from preventable disease and early death notwithstanding the possibility of advanced care. These significant health disparities exist along many axes, including race and ethnicity.[4] Black and Hispanic children with heart conditions are more likely to die than their white counterparts,[5] Black men are twice as likely to die of prostate cancer than white men,[6] and a Black mother is up to four times more likely than a white one to die from childbirth-related complications—with significant disparities existing even controlling for socioeconomic status, lifestyle, insurance coverage,

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[4] *See*, *e.g.*, Bruce G. Link, *Epidemiological Sociology and the Social Shaping of Population Health*, 49 J. Health & Soc. Behav. 367, 372-75 (2008).

[5] *See*, *e.g.*, Jillian Olsen et al., *Racial Disparities in Hospital Mortality Among Pediatric Cardiomyopathy and Myocarditis Patients*. 42 Pediatr. Cardiology 59, 68 (2021).

[6] *See, e.g.,* Paul Riviere et al., *Survival of African American and Non-Hispanic White Men With Prostate Cancer in an Equal-Access Health Care System*, 126 Cancer 1683, 1683, 1686 (2020).

and other factors.[7] Thousands of other studies have documented race-linked health inequities pervading nearly every index of human health, which combine to result in an overall reduced life expectancy for racial and ethnic minorities that cannot be explained by genetics.[8] And the COVID-19 pandemic brought that impact into sharp focus, with Black and Hispanic Americans roughly twice as likely to be hospitalized or die from that disease as their white counterparts—and with even graver outcomes for American Indian and Alaskan Natives.[9]

Although more of the population is insured now than previously, "significant disparities by race, ethnicity, household income, and location of residence persist for access to health insurance[,] access to dental

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[7] *See* Virginia Tangel et al., *Racial and Ethnic Disparities in Maternal Outcomes and the Disadvantage of Peripartum Black Women: A Multistate Analysis, 2007-2014*, 36 Am. J. Perinatology 835, 835, 843 (2019).

[8] *See*, *e.g.*, Timothy Cunningham et al., *Vital Signs: Racial Disparities in Age-Specific Mortality Among Blacks or African Americans—United States 1999-2015,* 66 Morb. Mortal. Weekly 444 (2017); Joshua Aronson et al., *Unhealthy Interactions: the Role of Stereotype Threat in Health Disparities*, 103 Am. J. Pub. Health 50 (2013); Valentina A. Zavala, et al., *Cancer Health Disparities in Racial/Ethnic Minorities in the United States*, 124 Brit. J. Cancer 315 (2021); Elbert J. Mets et al., *Persistent Disparities in Breast Cancer Surgical Outcomes Among Hispanic and African American Patients*, 45 Eur. J. Surgical Oncology, 584 (2019); Samir Soneji et al., *Racial and Ethnic Disparities in Early-Stage Lung Cancer Survival*, 152 Chest J. 587 (2017). *Cf.* Noah A. Rosenberg et al., *Genetic Structure of Human Populations*, 298 Sci. 5602 (2002) (confirming consensus that race is not genetic).

[9] *See*, *e.g.*, CDC, *Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity* (Feb 2, 2022) (https://tinyurl.com/2p8ft9hm).

insurance[,] * * * having an ongoing source of care, receiving timely care, and receiving care when needed."[10] When new technologies emerge to fight disease, minorities experience substantially slower and fewer benefits.[11] While some disparities are due to decreased access to healthcare in minority communities, the disparities persist even where access is universal, such as in veterans' care.[12]

Moreover, minority communities remain medically underserved. Communities with high proportions of Black and Hispanic residents are far more likely to have physician shortages, regardless of income levels.[13] And that problem is exacerbated by the fact that minorities, due in part to a long history of discriminatory medical practices,[14] express far lower levels of trust in the Nation's medical system. In a recent poll, 59% of Black Americans said they believe Blacks are "treated less fairly than whites" when

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[10] U.S. Dep't of Health & Human Servs., Agency for Healthcare Research & Quality, *2021 National Healthcare Quality and Disparities Report*, at ES-2 (2021) (https://tinyurl.com/3ek4zbay).

[11] *See* Link, *supra* note 4, at 370-72.

[12] *See* Heena P. Santry & Sherry M. Wren, *The Role of Unconscious Bias in Surgical Safety and Outcomes*, 92 Surg. Clinics N. Am. 137, 140 (2012).

[13] *See*, *e.g.*, Joel S. Weissman et al., *Residents' Preferences and Preparation for Caring for Underserved Populations*, 78 J. Urb. Health 535, 536 (2001); Kara Odom Walker et al., *The Association Among Specialty, Race, Ethnicity, and Practice Location Among California Physicians in Diverse Specialties*, 104 J. Nat'l Med. Ass'n 46, 46-47 (2012).

[14] *See*, *e.g.*, Darcell P. Scharff et al., *More Than Tuskegee: Understanding Mistrust About Research Participation*, 21 J. Health Care Poor & Underserved 879 (2010).

seeking medical treatment.[15] It is thus little surprise that while there is no race-linked difference in awareness of healthy lifestyle choices,[16] Black Americans use primary care offices at two-thirds the rate of whites, instead relying more heavily on emergency care.[17]

### B. Diversity In Medical Education Markedly Improves Health Outcomes.

The data set forth above is severely troubling. Fortunately, however, studies also confirm that diversity in medical education and practice can help alleviate many of the disparities mentioned. Black and Hispanic medical school graduates are on average likelier than others to consider serving underserved communities. By graduation, 56% of Black and 42% of Hispanic students express interest in practicing with the underserved.[18] A 2015 Senate Report likewise found that "[d]iversity among medical school students is associated with * * * greater willingness to

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[15] Pew Research Center, *Race in America 2019* (https://tinyurl.com/ypnametz); *see also* Christopher Mathis, *African Americans and Their Distrust of the Health Care System: Healthcare for Diverse Populations*, 14 J. Cultural Diversity 56 (2007) (discussing history of distrust of the healthcare system and proposing remedies).

[16] *See*, *e.g.*, Stephanie A. Robert & Bridget C. Booske, *US Opinions on Health Determinants and Social Policy as Health Policy*, 101 Am. J. Pub. Health 1655 (2011).

[17] *See* M.J. Arnett et al., *Race, Medical Mistrust, and Segregation in Primary Care as Usual Source of Care: Findings from the Exploring Health Disparities in Integrated Communities Study*, 93 J. Urb. Health 456, 461-64 (2016).

[18] Douglas Grbic & Franc Slapar, *Changes in Medical Students' Intentions to Serve the Underserved: Matriculation to Graduation*, 9 Analysis in Brief No. 8, at 2 (AAMC July 2010).

serve diverse populations," and that "minority health professionals are more likely to serve in areas with high rates of uninsured and areas of underrepresented racial and ethnic groups."[19] And a 2021 study confirmed that minority health professionals have demonstrably higher rates of following through on stated commitments to practice in underserved communities.[20] Underserved communities are thus particularly dependent on racially and ethnically diverse care teams.[21]

Moreover, there is evidence that a racially diverse care team can produce measurably positive health outcomes for minority patients,[22] both as a result of increased comfort or trust[23] and due to insights into care arising from personal knowledge or experience.[24]

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[19] S. Rep. No. 114-74, at 42 (2015).

[20] *See* Patricia Pittman et al., *Health Workforce for Health Equity*, 59 Medical Care S405, S405-S408 (2021); I.M. Xierali & M.A. Nivet, *The Racial and Ethnic Composition and Distribution of Primary Care Physicians*, 29 J. Health Care Poor & Underserved 556, 556-57 (2018).

[21] *See generally* Somnath Saha & Scott A. Shipman, *Race-Neutral Versus Race-Conscious Workforce Policy To Improve Access To Care*, 27 Health Affs. 234 (2008).

[22] Marcella Alsan et al., *Does Diversity Matter for Health? Experimental Evidence from Oakland*, 109 Am. Econ. Rev. 4071, 4074-75 (2019) (controlled study showed Black men were 18 percent more likely to seek preventive care measures after consultation with a Black physician); *see also* Greenwood, *supra* note 3, at 21195-97.

[23] *See*, *e.g.,* S.A. Kraft et al.*, Beyond Consent: Building Trusting Relationships With Diverse Populations in Precision Medicine Research*, 18 Am. J. Bioeth. 3 (2018).

[24] *See*, *e.g.*, Soo Yuon, *She Woke Up From Her Surgery With Her Hair Perfectly Braided. Her Black Male Doctor Had Done It.*,

And teams of racially diverse physicians and researchers are more likely to focus on identifying medical interventions needed for racial and ethnic minorities.[25]

To be clear: while increasing the racial and ethnic diversity of the medical professions will improve health outcomes, it is of course neither socially desirable nor realistic for minority patients to be treated exclusively by physicians of their own race or ethnicity. The goal of the health professions is not racially segregated care, but rather a workforce in which racial and ethnic representation is a more common aspect of care teams, professionals of all races and ethnicities are able to establish trustful therapeutic relationships with all patients, and the corresponding improvements in health outcomes are experienced as widely as possible. As shown below, in pursuit of that outcome, racially and ethnically diverse peer learning and support is urgently needed to educate the entire medical profession.

To that end, in addition to training more diverse physicians, medical schools also seek to train a diversity-***educated*** workforce—*i.e.*, one filled with physicians who possess what the profession has called cultural competence. These are physicians who are familiar with the connection between socio-cultural factors and health beliefs and behaviors and who have both the tools and skills to manage these factors

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The Lily (June 26, 2020) (https://tinyurl.com/ppka8up2) (improved recovery from surgery due to insights of Black surgeon on selecting incision site and braiding hair around incision).

[25] Sam S. Oh et al., *Diversity in Clinical and Biomedical Research: A Promise Yet to Be Fulfilled*, 12 PLoS Med. 1, 4-6 (2015).

appropriately to help eliminate socio-cultural barriers to care[26] and the humility and understanding to avoid stereotypes about patients from those cultures.[27] Training alongside people with diverse backgrounds can challenge faulty heuristics, improving the crucial care component of effective patient-physician communication.[28]

Based on scientific evidence, medical schools are committed to fostering a diverse educational environment because a diverse student body produces measurable public health benefits. For example, as noted, studies showed that white physicians were more likely to assume Black patients had a higher tolerance for pain, and resultingly prescribed them less pain medication.[29] In response to the risks associated with these and other misconceptions, cultural competence has been made a core requirement for entering medical students.[30] And to maintain accreditation medical school curriculums must include cultural competency training, including "the knowledge, skills, and core professional

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[26] *See* Joseph R. Betancourt et al., *Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care*, 118 Pub. Health Reports 293, 297-300 (2003).

[27] Sunila J. Prasad et al., *Cultural Humility: Treating The Patient, Not The Illness*, 21 Med. Educ. Online 30908 (2016).

[28] *Cf.* Jonathan M. Metzl & Helena Hansen, *Structural Competency: Theorizing A New Medical Engagement With Stigma And Inequality*, 103 Soc. Sci. & Med. 126, 128-32 (1982).

[29] *See supra* note 2 and accompanying text.

[30] AAMC Group on Student Affairs Committee on Admissions, *The Core Competencies for Entering Medical Students* (https://tinyurl.com/dk23w9np).

attributes needed to provide effective care in a multidimensional and diverse society."[31]

But this competency cannot simply be imposed from the top down. Such instruction, by itself, can have the unintended outcome of a false sense of expertise, inoculation from error, or deepened attachment to prior beliefs, resulting in a paradoxical increase in errors.[32] But a vast amount of research confirms that members of diverse healthcare teams are less likely to make the types of mistakes they might make in a more culturally homogenous environment.[33] Simply working in a diverse team also increases the expectation and acceptance of respectful inquiry and challenged assumptions.[34] Medical schools therefore pair classroom instruction with peer-to-peer learning[35] for its demonstrated ability to improve

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[31] LCME, *Standards for Accreditation of Medical Education Programs Leading to the MD Degree*, Standard 7.6 (https://tinyurl.com/ycksbynb).

[32] *See* Javeed Sukhera et al., *Implicit Bias and the Feedback Paradox: Exploring How Health Professionals Engage With Feedback While Questioning Its Credibility*, 94 Acad. Med. 1204, 1204-1210 (2019).

[33] L.E. Gomez & Patrick Bernet, *Diversity Improves Performance and Outcomes*, 111 J. Nat'l. Med. Ass'n, 383, 384-89 (2019).

[34] *See*, *e.g.*, Roland A. Owens, *The Carter Lab at NIH: A Model of Inclusive Excellence in Biomedical Research*, 31 Hum. Gene Therapy 512, 512-17 (2020) (describing the benefits of diverse team of researchers in the development of gene therapy vectors).

[35] *See* Emory Morrison & Douglas Grbic, *Dimensions of Diversity and Perception of Having Learned From Individuals From Different Backgrounds: The Particular Importance of Racial Diversity*, 90 Acad. Med. 937, 940-42 (2015).

receptivity to others' insights.[36] And education with diverse peers has been shown to facilitate more meaningful cross-cultural learning.[37]

Medical students who are educated in a diverse student body are thus better able to work with patients of diverse backgrounds.[38] In the healthcare arena, "[r]esearch shows that diverse teams working together and capitalizing on innovative ideas and distinct perspectives outperform homogenous teams. Scientists and trainees from diverse backgrounds and life experiences bring different perspectives, creativity, and individual enterprise to address complex scientific problems."[39]

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[36] Teresa Loda et al., *Cognitive and Social Congruence in Peer-Assisted Learning—A Scoping Review*, PLOS ONE (2019) (https://tinyurl.com/ye27rfs8).

[37] Jeffrey Polzer et al., *Capitalizing on Diversity: Interpersonal Congruence in Small Work Groups*, 47 Admin. Sci. Q. 296, 316 (2002).

[38] Gretchen Guiton et al., *Student Body Diversity: Relationship to Medical Students' Experiences and Attitudes*, 82 Acad. Med. S85, S87 (Supp. 2007); *see also*, *e.g.*, Somnath Saha et al., *Student Body Racial and Ethnic Composition and Diversity-Related Outcomes in US Medical Schools*, 300 JAMA 1135, 1135 (2008) (finding that non-minority students attending more racially diverse medical schools exhibited greater preparedness to care for minority patients and stronger attitudes about equitable access to healthcare).

[39] NIH, *Diversity Statement* (https://tinyurl.com/3b2xpdbm); *see also* Lu Hong & Scott E. Page, *Groups of Diverse Problem Solvers Can Outperform Groups of High-Ability Problem Solvers*, 101 Proc. Nat'l Acad. Scis. 16385 (2004) (finding that diverse groups perform more productively and creatively than non-diverse ones).

### C. Medical Professionals, Not Judges, Are Best Suited To Determine How To Prepare Students To Meet Patients' Diverse Needs.

Diversity in medical school admissions is thus not an end in itself, but rather a means to achieving core educational and medical goals defined by each institution.[40] 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 in medical education 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 determines for itself how best to apply diversity principles in pursuing its institutional goals.

For most medical schools, these goals include producing culturally-competent physicians who are well-adapted to serve patients from across the varied

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[40] *See* Amy N. Addams et al., *Roadmap to Diversity: Integrating Holistic Review Practices into Medical School Admission Processes*, at ix (AAMC 2010) (https://tinyurl.com/2p96phej).

racial and ethnic makeup of the Nation. As this Court recognized in *Grutter*, "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). For the medical professions, these benefits are particularly important because human lives are directly at stake. A diverse student body helps to promote the empathy, emotional intelligence, and cultural understanding required of physicians and other healthcare professionals in a diverse world. These benefits of diversity in health-professional education have been recognized by Congress,[41] students,[42] and faculty.[43]

To select candidates embodying 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

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[41] *See* Disadvantaged Minority Health Improvement Act of 1990, Pub. L. No. 101-527, § 1(b)(12), 104 Stat. 2311, 2312 (1990) (finding that "diversity in the faculty and student body of health professions schools enhances the quality of education for all students attending the schools").

[42] *See*, *e.g.*, Dean K. Whitla et al., *Educational Benefits of Diversity in Medical School: A Survey of Students*, 78 Acad. Med. 460, 466 (2003) (medical school students overwhelmingly reported that contacts with diverse peers greatly enhanced their educational experiences).

[43] *See*, *e.g.*, Robert A. Witzburg & Henry M. Sondheimer, *Holistic Review—Shaping the Medical Profession One Applicant at a Time*, 368 New Eng. J. Med. 1565, 1567 (2013) (according to medical school faculty, students selected through holistic review are "more collegial, more supportive of one another, more engaged in the curriculum, and more open to new ideas and to perspectives different from their own").

experiences, and disparate racial, ethnic, and economic backgrounds, among others. A richly diverse class can contribute to a dynamic, multidimensional educational environment where classroom and study-group discussions add insight to course materials. As Justice Powell put it, "[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 313 (Powell, J.) (citation omitted).

For the healthcare professions, racial and ethnic diversity is thus not merely an abstract goal, but a medical imperative. Amici have concluded that a diverse educational environment is essential to training physicians who can best address the healthcare needs of this Nation's diverse people. The bodies responsible for accrediting medical schools likewise recognize the important role that student diversity plays in the effective delivery of healthcare.[44] There can be no more compelling interest than that. And as the Court has repeatedly reaffirmed, this educational and medical judgment warrants deference.[45]

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[44] *See*, *e.g.*, LCME, *supra* note 31, at 4 (Standard 3.3 noting that a medical should maintain "effective policies" for "achiev[ing] mission-appropriate diversity outcomes").

[45] *See*, *e.g.*, *Fisher II*, 579 U.S. at 388 ("Considerable deference is owed to a university in defining those intangible characteristics, like student body diversity, that are central to its identity and educational mission."); *Fisher I*, 570 U.S. at 311 ("*Grutter* calls for deference to the University's conclusion, 'based on its experience and expertise,' that a diverse student body would serve its educational goals.") (citation omitted); *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."); *cf. Sch. Bd. of Nassau Cnty.* v. *Arline*, 480 U.S. 273,

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

A strong grasp of biological sciences and demonstrated academic strengths are prerequisite to the study of medicine. However, consideration of grades and test scores alone is insufficient to select a student body that will achieve a school's distinct educational goals and mission. Thus, most medical schools have adopted holistic review processes similar to those upheld by this Court in *Grutter* and *Fisher II*.[46] Holistic review is a flexible, highly individualized consideration of the multiple ways in which medical school applicants can demonstrate that they fit well within a given institution. In that regard, the process is not unlike judicial clerkship hiring, which also depends on holistic, individualized review that takes account of all attributes in the hope of fielding "a winning team, not just a single all-star."[47] The goal of most health-professional schools is to evaluate each applicant fully and individually, compiling a class of

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288 (1987) ("[C]ourts normally should defer to the reasonable medical judgments of public health officials[.]").

[46] In 2014 , 93% of dental schools, 91% of medical schools, 82% MPH schools, 78% of pharmaceutical schools, and half of nursing schools surveyed reported using holistic review. *See* Greer Glazer et al., *Holistic Admissions in the Health Professions: Findings From A National Survey*, Urb. Univs. Health, at 11 (2014) (https://tinyurl.com/2p8zs54n).

[47] *See* Christopher D. Kromphardt, *Fielding an Excellent Team: Law Clerk Selection and Chambers Structure at the U.S. Supreme Court*, 98 Marq. L. Rev. 289, 289 (2014) (noting that judges and Justices "exercise wide discretion when hiring law clerks").

interdependent learners, and furthering each school's educational mission.[48]

### A. Medical Schools Have Historically Engaged In Highly Individualized Admissions Practices.

The qualities that make a healthcare professional successful are impossible to measure based on 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 teamwork skills, among other characteristics."[49]

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 by school, all medical schools consider a range of non-academic factors. Medical schools have never exclusively or even predominantly relied on numerical criteria to select their student bodies.[50] While undergraduate GPA and MCAT scores are usually high on the list of considerations in

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[48] *See* Sarah S. Conrad et al., *Holistic Review in Medical School Admissions and Selection: A Strategic, Mission-Driven Response to Shifting Societal Needs*, 91 Acad. Med. 1472, 1473-74 (2016).

[49] Dana Dunleavy et al., *Medical School Admissions: More than Grades and Test Scores*, 11 Analysis in Brief No. 6, at 1 (AAMC Sept. 2011) (footnotes omitted).

[50] *Cf.* Filo 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 the Health Professions 305, 305-07 (Inst. of Med. 2001).

determining which applicants to interview, medical schools rank personal interviews and, to a lesser extent, letters of recommendation as the most important considerations in final acceptance decisions.[51] Once an applicant meets the academic requirements to succeed in medical school, the MCAT score is no longer as important as other qualitative indicators of characteristics such as bedside manner, altruism, and community engagement.[52] These qualitative factors are so critical that between 2019 and 2022, more than 15% of applicants with the highest levels of both GPA and MCAT scores were nevertheless rejected by ***all*** medical schools to which they applied.[53]

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 and the school's specific mission. A survey of health-professional schools tied holistic review to the institution-specific missions of serving underserved rural communities, serving underserved urban communities, research, primary care, and global health.[54]

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[51] *See* Dunleavy et al., *supra* note 49, at 2.

[52] *Cf. id.* at 1-2; Carol A. Terregino et al., *The Diversity and Success of Medical School Applicants With Scores in the Middle Third of the MCAT Score Scale*, 95 Acad. Med. 344, 345-46 (2020).

[53] *See* AAMC, *MCAT and GPA Grid for Applicants and Acceptees to U.S. MD-Granting Medical Schools, 2019-2020 through 2021-2022 (aggregated)* (https://tinyurl.com/mr2txenv) (table A-23).

[54] *See* Glazer et al., *supra* note 46, at 20.

For some schools, the range of factors considered during holistic review may include race and ethnicity. However, these factors are considered only as necessary to achieve articulated, mission-driven benefits. To the extent race is considered, this Court has already held that it should not be considered in isolation, and there is no reason to doubt that medical educators adhere to that directive. Race 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 many cases be intertwined with a person's race or ethnicity. Further, an applicant's background is a strong predictor of the population or environment in which they will ultimately practice.[55] For example, minority dental-school applicants are more likely than their peers to rate "the desire to work in my own cultural community" as important influences on their choice of practice.[56] And as noted above, minority health professionals have been historically and consistently more likely to follow through with stated commitments to serve underserved communities.[57]

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[55] *See* Howard K. Rabinowitz et al., *The Relationship Between Entering Medical Students' Backgrounds and Career Plans and Their Rural Practice Outcomes Three Decades Later*, 87 Acad. Med. 493, 493-95 (2012); Ian T. MacQueen et al., *Recruiting Rural Healthcare Providers Today: a Systematic Review of Training Program Success and Determinants of Geographic Choices*, 33 J. Gen. Internal Med. 191, 195 (2017).

[56] Elizabeth A. Mertz et al., *Underrepresented Minority Dentists: Quantifying Their Numbers And Characterizing The Communities They Serve*, 35 Health Affs. 2190, 2195 (2016).

[57] *See* Pittman et al., *supra* note 20.

Accordingly, when candidates have overcome challenges, experienced marginalization, or indicated a commitment to serving a particular place or community, obscuring or denying consideration of those applicants' backgrounds will hinder a full appreciation of their potential contributions.

### B. It Remains Necessary For Medical Schools To Consider Applicants' Full Backgrounds In Order To Achieve Educational And Professional Aims.

Consistent with the requirements of narrow tailoring, direct consideration of race may continue only as necessary to achieve core aspects of institutions' educational missions. As evidenced by the degree of enduring under-representation in medicine for certain minority groups notwithstanding intensive efforts by medical schools to diversify their classes through race-neutral means, consideration of an applicant's racial or ethnic background is still necessary if a school seeks diversity on those grounds.

Unlike other historically excluded groups, such as women, [58] racial minorities did not organically approach representative parity in the health professions once the most obvious barriers to entry were removed. To the contrary, minorities continue to be significantly underrepresented in the health professions. [59] For instance, in 2019, only 7.3% of

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[58] *See* Devin B. Morris et al., *Diversity of the National Medical Student Body—Four Decades of Inequities*, 384 New Eng. J. Med. 1661, 1662-63 (2021) (showing that medical school enrollment achieved representative gender equity around 2005).

[59] *See* Edward Salsberg et al., *Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce*, JAMA Network Open (2021); *see also*

advanced practice registered nurses, 5.2% of physicians, and 4.4% of dentists identified as Black, even though Blacks make up 12.1% of the working-age population.[60] Hispanic people (18.2% of the working-age population) represent only 5.5% of advanced practice registered nurses, 6.9% of physicians, and 5.7% of dentists. *See id.* When examined by medical specialty, underrepresentation has intensified over time, with Black, Hispanic, and Native Americans showing statistically significant downward trends across nearly all ranks and specialties.[61] To take one example, Black men constitute an even smaller percentage of medical students than they did in 1978, when *Bakke* was decided.[62]

Medical schools continue to implement a host of race-neutral initiatives outside 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 this success has not been universal, and such initiatives are nowhere close to being a complete answer. To discharge their obligations to produce well-trained health professionals who are prepared to serve all of

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AAMC, *Diversity in Medicine: Facts and Figures 2019, Executive Summary* at 3 (https://tinyurl.com/4z5sevr9.

[60] *See* Salsberg et al., *supra* note 59 (Tables 1 & 2).

[61] *See* Elle Lett et al., *Declining Racial And Ethnic Representation In Clinical Academic Medicine: A Longitudinal Study of 16 US Medical Specialties*, PLOS ONE (Nov. 16, 2018) (https://tinyurl.com/2n5934vu).

[62] *See* Morris et al., *supra* note 58, at 1663-64.

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.

Ultimately, schools are constrained by the size and demographics of their own applicant pool and the overall applicant pool that year. For example, if there are fewer Native American applicants than there are medical schools, many schools will end up with zero Native American matriculants, as in fact often happens.[63] Due to a combination of challenges, students from many minority groups are less likely to enroll in college (and particularly unlikely to enroll at top colleges), and they are therefore less likely to have the competitive preparation and support to apply to medical school.[64] To combat those trends, health-professional schools make significant investments in early interventions to diversify the applicant pool, including mentoring and enrichment programs for

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[63] *See*, *e.g.*, AAMC, *Total Enrollment by U.S. MD-Granting Medical School and Race/Ethnicity (Alone), 2021-2022* (https://tinyurl.com/5n6f68mu).

[64] *See* Nat'l Ctr. Educ. Stat., *College Enrollment Rates*, The Condition of Education, at 2 (2020) (https://tinyurl.com/yr3wp9w7); Jorge A. Girotti et al., *Investigating Group Differences in Examinees' Preparation for and Performance on the New MCAT Exam,* 95 Acad. Med. 365, 369-70 (2020) (explaining that students attending colleges with more resources have higher MCAT scores on average than students attending colleges); Jonathan Rothwell, *Black Students at Top Colleges: Exceptions, Not the Rule*, Brookings Social Mobility Memos (Feb. 3, 2015) (https://tinyurl.com/2p8kb9dz) (explaining that Black students make up a smaller share of the student body at top colleges than at lower-ranked colleges).

middle school,[65] high school,[66] and college students;[67] summer enrichment programs[68] and other "pathway" programs that seek to encourage and prepare minority students to pursue health-professional education;[69] and postbaccalaureate programs.[70] But while these programs have shown some success,[71] their overall impact cannot fully overcome the many

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[65] *See*, *e.g.*, Morehouse School of Medicine's Ben Carson Science Academy Website (https://tinyurl.com/476hc5wj) (former preparatory program for students in elementary and middle school).

[66] *See*, *e.g.,* Behnoosh Afghani et al., *A Novel Enrichment Program Using Cascading Mentorship to Increase Diversity in the Health Care Professions*, 88 Acad. Med. 1232, 1232-33 (2013).

[67] *See*, *e.g.,* Monica B. Vela et al., *Improving Underrepresented Minority Medical Student Recruitment with Health Disparities Curriculum*, 25 J. Gen. Internal Med. S82, S83-S85 (Supp. 2 2010).

[68] *See, e.g.,* Clemencia Cosentino et al., *Impact Evaluation of the RWJF Summer Medical and Dental Education Program (SMDEP)* (Mathematica Jan. 28, 2015) (https://tinyurl.com/2smmjxkp).

[69] Morehouse School of Medicine hosts the National Health Sciences STEM Pipeline Repository to enhance replication of effective pipeline and pathway programs and best practices. *See* Morehouse School of Medicine, *National Health Sciences STEM Pipeline Repository* (https://tinyurl.com/f2bch5ar).

[70] *See* Dorothy Andriole et al., *Postbaccalaureate Premedical Programs in the U.S.: Results of a National Survey*, 18 Analysis in Brief No. 6 (AAMC Nov. 2018) (https://tinyurl.com/45xafdk4).

[71] *See* Douglas Grbic et al., *Association of Summer College Academic Enrichment Program Participation With Medical Student Diversity and Intent to Practice in Underserved Areas*, JAMA Network Open, at 3 (2021).

external demographic forces that are beyond schools' ability to control.[72]

Although minority medical school applicants are critically needed to create the kind of diverse classrooms that will help foster cultural competency, their numbers, as noted above, remain very low. Even once exclusion at the higher-education level ceased, societal forces continue to prevent a disproportionate percentage of minority students from building upon a steady foundation for a career in medicine.[73] Most medical school applicants' preparation begins at a young age, with successful applicants having been aided by a combination of early and ongoing resources, quality primary and college education, opportunities, mentoring, role models, financial stability, and academic preparation, among other factors.[74]

Low-income applicants from all racial and ethnic backgrounds are significantly less likely to have benefitted from these ongoing and early support and resources. Between 73% and 79% of all students entering medical school were raised in homes in the

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[72] *See*, *e.g.*, Emory Morrison & David A. Cort, *An Analysis of the Medical School Pipeline: A High School Aspirant to Applicant and Enrollment View*, 14 Analysis in Brief No. 3, at 1-2 (AAMC 2014) (among high school students expressing interest in becoming a physician, those who change their minds are disproportionately from groups least represented in medicine).

[73] *See* Yasmeen Daher et al., *The History Of Medical Education: A Commentary on Race*, 121 J. Osteopath Med. 163, 168 (2021).

[74] *See* Jenée Farrell et al., *Who Enters The Health Workforce? An Examination of Racial and Ethnic Diversity*, Fitzhugh Mullan Institute for Health Workforce Equity, George Washington University, at 2 (2022).

top two household-income quintiles.[75] And only 5% of medical school matriculants come from households in the lowest 20%. *See id.* Groups underrepresented in medicine disproportionately live in communities with lower household incomes and historically fewer opportunities for wealth accumulation, reducing the likelihood that members of those groups will have the resources to prepare for medical school. And counterintuitively, focusing in admissions on statistical information that correlates with race—such as socio-economic status—would likely reduce rather than increase the number of minority applicants accepted for admission, because low-income minority students are less likely than their non-minority peers to have had access to other resources and support in their early and collegiate years.[76]

Further, medical and other advanced education runs in families. Approximately 73% of medical school matriculants have a parent with an advanced degree,[77] and children and grandchildren of physicians are more likely to become physicians than

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[75] *See* Jay Youngclaus et al., *An Updated Look at the Economic Diversity of U.S. Medical Students*, 18 Analysis in Brief No. 5, at 2 (AAMC Oct. 2018).

[76] *See* 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: Long-Term Consequences of Considering Race in College and University Admissions 270-71 (Twentieth Anniversary ed. 1998).

[77] *See* Youngclaus et al., *supra* note 75, at Table 1 (data aggregated).

children of other professions.[78] The generational experiential inheritance of familial mentorship, beneficial connections, and immersive skill development increases the likelihood of pursuing the medical profession.[79] But the numbers and overall percentages of minority physicians have historically been small. Most medical schools did not admit students from ethnic and racial minority groups until the 1960's and all but two medical schools opened specifically for Black physicians were closed by 1923, serving as a longstanding barrier to the accumulation of professional experiential wealth in these communities.[80]

For these and other reasons, the legacy of American racial injustice has endured longer across the healthcare and medical-education systems than many might have predicted. As a result, notwithstanding significant investment and effort by health-professional programs, if a program seeks a racially diverse student body with more than token representation, most schools will necessarily continue to rely on the consideration of an applicant's racial or

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[78] *See* Bernard F. Lentz & David N. Laband, *Why So Many Children of Doctors Become Doctors: Nepotism vs. Human Capital Transfers*, 24 J. Hum. Res. 396, 407 (1989).

[79] *See* Lada Adamic & Ismail Onur Filiz, *Do Jobs Run in Families?*, Meta (Mar. 17, 2016) (https://tinyurl.com/4abyssrf); *See also* Maria Polyakova et al., *Does Medicine Run In The Family—Evidence from Three Generations of Physicians in Sweden: Retrospective Observational Study*, BMJ (2020).

[80] *See* Terri Laws, *How Should We Respond to Racist Legacies in Health Professions Education Originating in the Flexner Report?*, 23 AMA J. Ethics 271, 272 (2021); Kendall M. Campbell et al., *Projected Estimates of African American Medical Graduates of Closed Historically Black Medical Schools*, JAMA Network Open, at 6 (2020).

ethnic background in some cases. And any prohibition on the consideration of race in student admissions will therefore result in a student body with significantly fewer minority students.

## III. PRECLUDING OR LIMITING HOLISTIC REVIEW WOULD RESULT IN A COMPOUNDING LOSS OF DIVERSITY AND THREATEN PATIENTS' HEALTH.

For nearly 45 years, the Nation's medical schools have utilized the kinds of holistic admissions processes this Court approved in *Bakke*, *Grutter*, and *Fisher II*. 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. Amici urge the Court not to disrupt that reliance by withdrawing its imprimatur from those longstanding practices.

The records of these cases confirm that no justification for parting from stare decisis exists here. For instance, far from being "unworkable," *Payne* v. *Tennessee*, 501 U.S. 808, 827 (1991), the processes approved in *Grutter*, *Bakke*, and *Fisher II* continue to be the predominant modes of decision making employed by health-professional schools across the Nation. By contrast, it would be difficult, if not impossible, to insulate all 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."[81] And because minorities report at vastly higher rates than white Americans that their race is important to their self-perception and identity,[82] requiring application materials to be truly race-blind would itself have a discriminatory effect. Medical school admissions, which have always relied heavily on personal interviews of every admitted applicant, could be drastically curtailed by such a system, to the ultimate detriment of the Nation's health.

Moreover, overruling *Grutter* would potentially trigger a spiral of severe and self-reinforcing decreases in diversity in the healthcare professions. States that have banned race-conscious admissions have seen the number of minority medical-school students drop by roughly 37% as a result.[83] That number reflects not only the immediate effect of alterations to medical-school admissions, but also the downstream effect of reduced diversity in undergraduate institutions in those states.[84] As the First Circuit acknowledged, part of the importance of maintaining a diverse student body stems from the fact that non-diverse institutions are less attractive and hospitable

[81] Devon W. Carbado & Cheryl I. Harris, *The New Racial Preferences*, 96 Cal. L. Rev. 1139, 1146-47, 1149 (2008).

[82] *See* Pew Research Center, *supra* note 15 (74% of Black, 59% of Hispanic, and 56% of Asian Americans state that their race is extremely or very important to their self-perception and identity compared to only 15% of white Americans).

[83] Dan Ly et al., *Affirmative Action Bans and Enrollment of Students From Underrepresented Racial and Ethnic Groups in U.S. Public Medical Schools*, 175 Annals Intern. Med. 873, 875 (2022).

[84] *See* Zachary Bleemer, *Affirmative Action, Mismatch, and Economic Mobility After California's Proposition 209*, Ctr. Stud. Higher Educ., at 24 (2020).

to minority applicants. *Harvard* Pet. App. 78-79. Diversity fosters more diversity, while homogeneity fosters more homogeneity. Any consideration of whether to risk reducing diversity in higher education must account for the risk of such a spiral, where institutions become not only less diverse, but also unable to attract minority applicants by virtue of their lack of diversity. Banning race-conscious admissions thus will imperil the health and lives of Americans. Amici urge the Court to refrain from taking such a potentially dangerous action.

## CONCLUSION

For the foregoing reasons, and those in respondents' briefs, the judgments should be affirmed.

Respectfully submitted,

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