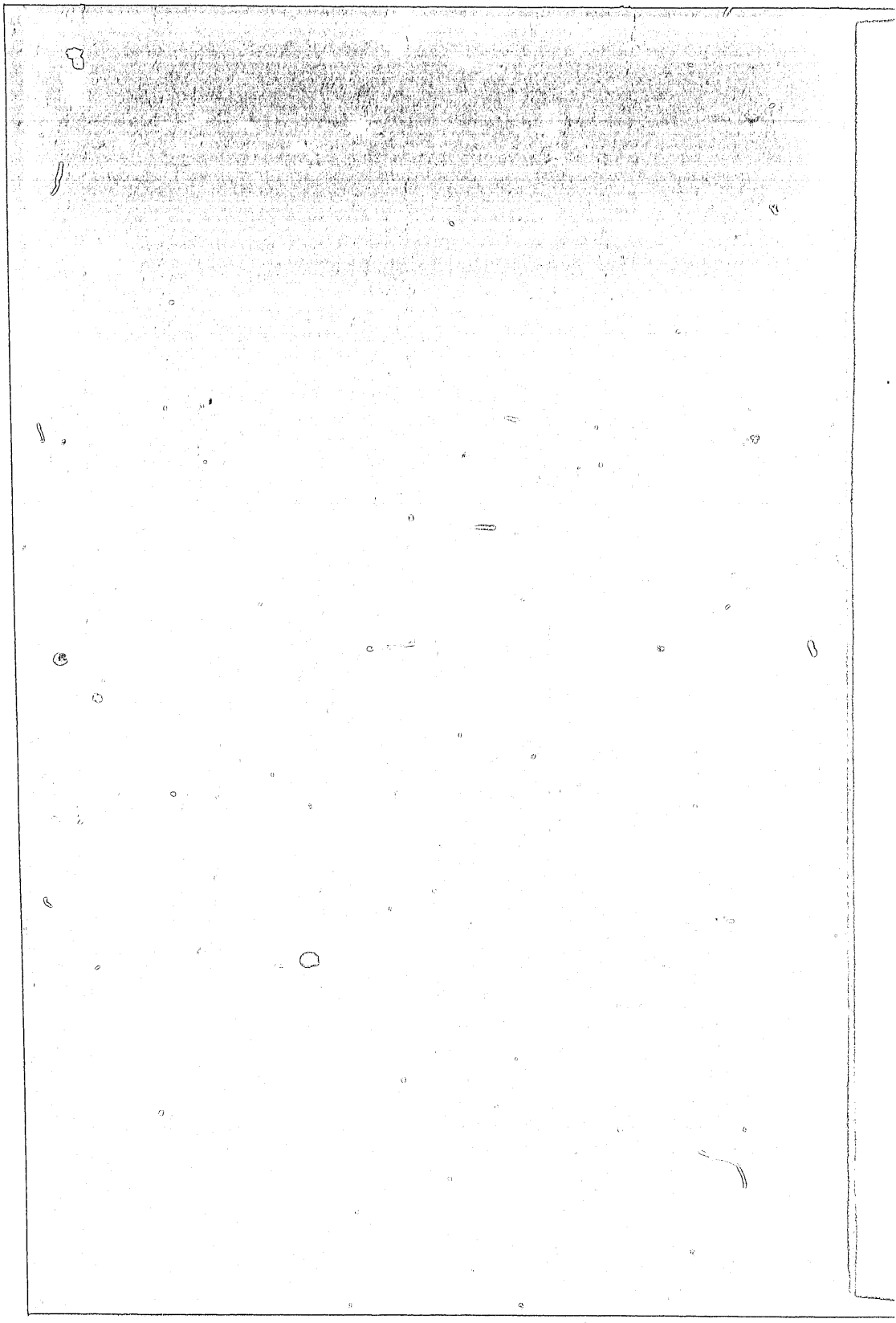

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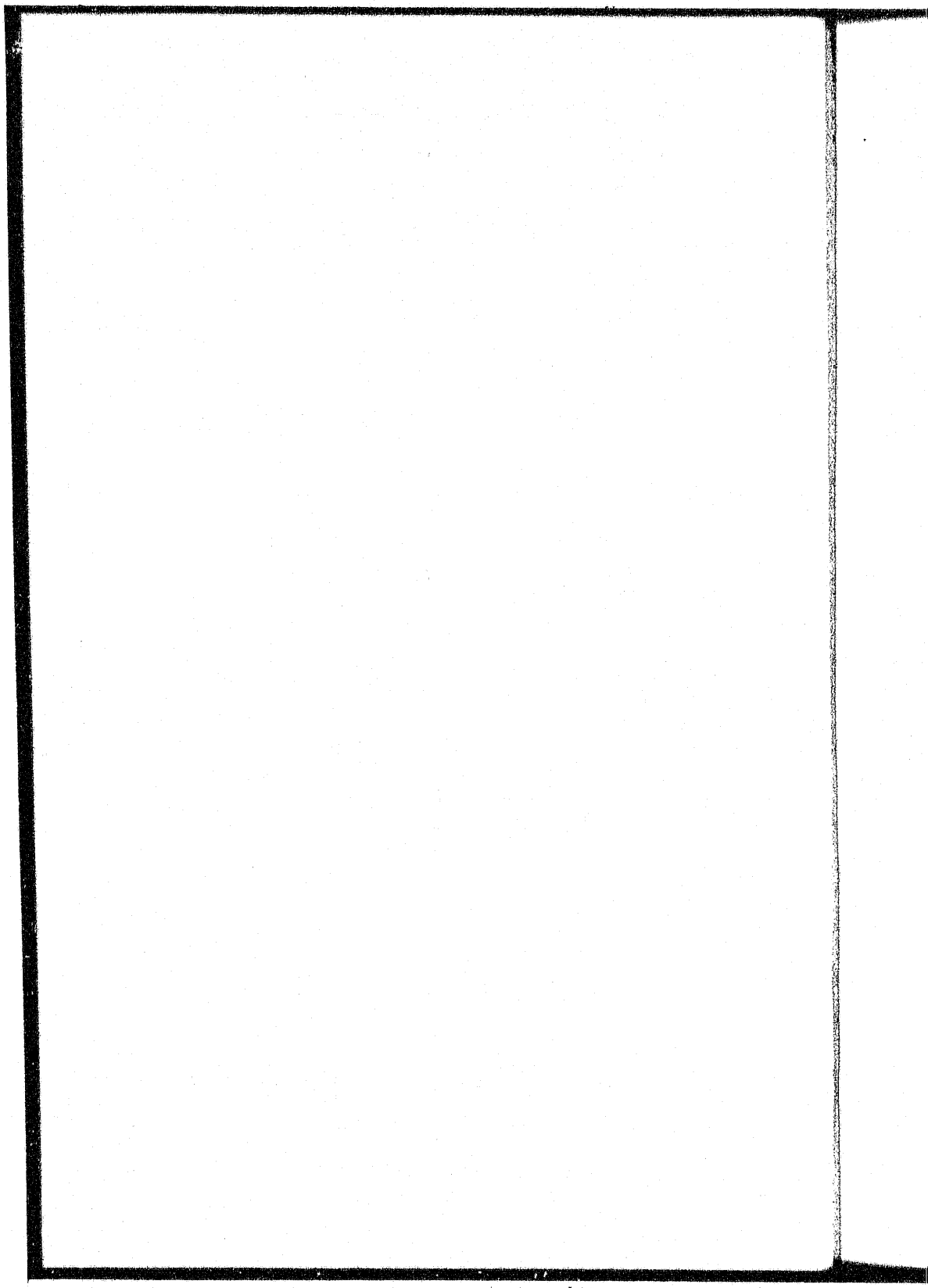

IN THE

Supreme Court of the United States

OCTOBER TERM, 1976

No. 76-811

THE REGENTS OF THE UNIVERSITY OF CALIFORNIA,
Petitioner,

v.

ALLAN BAKKE, *Respondent*

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit Supreme Court of the State of California

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BRIEF FOR AMICI CURIAE

FOR JEROME A. LACKNER, M.D., J.D., DIRECTOR OF THE DEPARTMENT OF HEALTH OF THE STATE OF CALIFORNIA, AND MARION J. WOODS, DIRECTOR OF THE DEPARTMENT OF BENEFIT PAYMENTS OF THE STATE OF CALIFORNIA

INTEREST OF AMICI CURIAE

The Department of Health of the State of California (DOH) is the largest state department of health services in the nation. In conjunction with the Department of Benefit Payments, the Department adminis-

ters health and social service programs which directly affect millions of California citizens.[1]

The objective of the Departments of Health and Benefit Payments is to improve and sustain in a uniform manner the quality and quantity of services that affect the health and welfare of the people of California. Services currently include health protection and care through the following: prevention and control of disease and disability; control of environmental health hazards; assurance of high quality health services through inspection and licensing; comprehensive planning for optimum use of health resources; coordination of direct treatment programs for the developmentally disabled, the mentally ill, and substance abusers; provision of welfare and social services to economically and socially deprived citizens; administration of the Medical Assistance Program (Medi-Cal) so as to maximize the use of public funds to provide medical services to the economically deprived; and delivery of direct treatment services through the 11 hospitals in the state hospital system.

Emphasis is placed on providing needed services to particular groups of the State's residents who have been traditionally underserved, such as farmworkers, American Indians, children from low-income families, senior citizens, and persons affected by unique genetic diseases. The Department of Health, has an annual budget of $4 Billion and employs 23,000 people in offices located in over 100 California cities, and the De-

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[1] The letters of consent from counsel for petitioners and respondent have been filed with the Clerk of the Court. Amici are grateful to Don Justin Jones, J.D., and Marcos Alonzo Nieto of the Civil Rights Office, California State Department of Health, for their contribution in the preparation of this Brief.

partment of Benefit Payments has over 3,000 employees and provides aid and services to several million Californians.

Echoing this Court's decisions in a legion of civil rights cases, the Departments recognize the paramount importance of providing available health resources to all residents of California regardless of race, creed or color.

As the 1970 census clearly evidences, Chicanos, Blacks, Asians, Philipinos, Samoans, and Native Americans make up a quarter of California's population. These groups are concentrated in a number of critical shortage areas for primary care physician hereinafter referred to as critical shortage areas.[2]

A cursory survey of the ethnicity of primary care physicians to the ethnic demography of California reveals egregious disparities:

TABLE 1

	Primary Care Physician: Community Ratio
Native American	1: 7539
Anglo	1: 990
Black	1: 4027
Chicano	1:21,245
Median	1: 1301

[2] Critical shortage areas for primary care are defined as geographical population centers in which the ratio of primary care physician—population exceeds 1:2248 which is 200% of the Health Manpower Commission's standard for adequate supply.

Thus while there is one Anglo primary care physician per 990 patients there is only one Chicano primary care physician per every 21,245 Chicanos.

The outcome of this case will have a substantial effect on these Departments ability to provide service to minorities and the poor in California who are currently deprived of available health resources.

Amici contend that minority admissions programs are neither the overzealous indiscretion of university administrators nor the inconsequential patronization of minorities that these programs have been made out to be. Rather, minority admissions are a vital and necessary part of the American health care systems. Absent any evidence as to the disastrous impact such a decision would have on the American health care system, Federal and state courts appear to be at the threshhold of dimantling minority admissions programs in medical schools.

The Court below was wholly without the pre-requisite evidence to assess an adverse decision's impact on critical shortage areas. *Cf. San Antonio Independent School District* v. *Rodriguez,* 411 U.S. 37, 42 (1973). As a Department charged with protecting the public health, the California Department of Health will measure the impact of an adverse decision in real deaths of real people.

SUMMARY OF THE ARGUMENT

This suit presents questions concerning the powers of a state to utilize an admissions program in which race is a factor. The California Supreme Court held that such programs violate the equal protection clause of the Fourteenth Amendment. We take the position that minority admissions programs are a vital and necessary part of the American health care system. The California Health Manpower Policy Commission annually identifies critical shortage areas. These areas have a high incidence of disease and an egregiously low number of available primary care physicians. There is an irrefutable correlation between critical shortage areas and minority population. These areas have abnormally high morbidity and mortality rates due in part to the absence of primary care physicians. Current population-primary care physician ratios in these areas are outrageous. Medical schools have an obligation to the public health of the State to identify methods by which this ratio can be brought within tolerable limits. Amici contend that minority admissions programs are the most effective method of action to ameliorate the health care crisis in critical shortage areas. Furthermore, Amici feel that the California court erred in its wooden application of the strict scrutiny test to a program designed to remedy the extreme absence of health care in critical shortage areas. For these reasons, the decision of the lower court was improvidently arrived at—indeed the lower court's decision failed to weigh the decision's impact on the public health—and should be reversed.

ARGUMENT

I.

MINORITY ADMISSIONS PROGRAMS ARE A VITAL AND NECESSARY PART OF THE CALIFORNIA HEALTH CARE SYSTEM.

A. Urban Critical Shortage Areas in California Are Correlated to Race.

The California Health Manpower Policy Commission annually identifies critical shortage areas for primary care physicians and reports their findings to the California Legislature. Generally, critical shortage areas in urban centers have been steadily growing. In addition, the ratio of patients to primary care physicians in these critical shortage urban areas has substantially increased. To physicians, the advantages of urban life are legion. However, their attraction has done little to reduce the primary care physician ratio in these critical shortage areas. Urban critical shortage areas in California share one catholic characteristic: a disproportionate number of minorities as residents.

In Los Angeles County, subdivisions of the County's health district areas are formed for the delivery of public health services. As can be seen in Table 2 in Los Angeles County, there are sixteen health district study areas designated as critical shortage areas. An analysis of the ethnic demographic characteristics for these areas indicate that the combined minority population in the sixteen critical shortage areas was over 50 percent. This figure is based on 1970 census data. Minority population shifts in these areas since 1970 make it highly probable that the combined minority population in the sixteen critical shortage areas now considerably exceeds this figure. This is so even though

less than one-third of the population of Los Angeles County is minority.

The average ratio of primary care physicians per patient in these sixteen areas is 1:3008. At least five of the areas had, in 1970, seventy-five to ninety-five percent minority population: Santa Barbara-West Adams, East Los Angeles-Maravilla, Exposition Park-South Vermont, Figueroa-Firestone-Greenmeadows-Watts, and Avalon-Goodyear. These areas form the barrios and ghettos of Los Angeles where the bulk of the County's minority population resides. In determining the minority population in the sixteen critical shortage areas, Department staff reviewed 375 census tracts and found that 246 or 65 percent were predominantly minority.

TABLE 2

List of Areas in Los Angeles County Designated as Critical Shortage Areas

Area	1970 Population	Primary Care Physicians 1976	Ratio	Population Minorities
1. Santa Barbara-West Adams	104,821	33	1:3176	92,493
2. Venice-Del Ray	70,269	22	1:3194	22,157
3. Dominguez-West Compton-Willowbrook	111,687	27	1:4137	46,307
4. Monterey Park-Rosemead	92,950	29	1:3205	22,293

5. East Los Angeles-City Terrace-Maravilla	102,668	29	1:3540	85,009
6. North El Monte-South El Monte	93,473	22	1:4249	31,974
7. Industry-La Puente-Baldwin Park	185,323	24	1:7722	63,767
8. El Sereno-Lincoln Heights-Mt. Washington-Highland Park	122,455	36	1:3402	73,606
9. Monrovia-Azusa-Glendora	145,636	57	1:2555	27,591
10. Pacoima-Sun Valley Sunland-Tujunga	154,877	45	1:3442	54,013
11. Maywood-Bell-South Gate	142,041	35	1:4058	31,433
12. East Inglewood-Gardena	108,036	41	1:2635	60,168
13. Exposition Park-South Vermont	119,284	49	1:2434	118,141
14. Avalon-Goodyear-Main	86,930	28	1:3105	77,833
15. Figueroa-Firestone Green Meadows-Watts	137,766	42	1:3280	106,699
16. Whittier-Santa Fe Springs-Pico Rivera	172,812	68	1:2341	67,991
TOTAL	1,951,019	587	1:3008	981,475

NOTE: Population data and percentage of minorities is from the 1970 census report for the Los Angeles-Long Beach Standard Metropolitan Statistical Area. Data on the number of primary care physicians was obtained from the Los Angeles County Department of Health Services.

In all of the areas designated as critical shortage areas, the primary care physician-population ratio inauspiciously and dangerously exceeds the 1:1124 ratio viewed as pre-requisite to adequate health care. The average ratio of primary care physicians per patient in these sixteen areas is 1:3008. Primary care physicians actually practicing in these areas, and thus geographically accessible to the persons residing in these areas are only approximately ⅓ the number of primary care physicians deemed necessary for adequate health care. One area, in fact, had only 1/7 of the primary care physicians necessary to serve the persons in that area.

A disproportionate number of the residents in critical shortage areas in the County are Chicano or Black: 52.3 percent of all minorities living in Los Angeles County live in the sixteen critical shortage areas while only 18.8 percent of the Anglos living in Los Angeles County live in these critical shortage areas. When the Chicano areas such as East Los Angeles, La Puente, El Monte, Pico Rivera and the Black areas of Santa Barbara-West Adams, Exposition Park, and Avalon-Goodyear are compared to the Anglo areas of Van Nuys, Santa Monica, Bel Air, and Beverly Hills, the primary care physician population ratios are easily seen to be many times greater for Chicanos and Blacks than for Anglos.

TABLE 3

Chicano Areas	Primary Care Physicians	Physician-Population Ratio
East Los Angeles	29	1:3540
La Puente	24	1:7722
El Monte	22	1:4249
Pico Rivera	68	1:2341
Black Areas		
Santa Barbara-West Adams	33	1:3176
Exposition Park	49	1:2434
Avalon-Goodyear	28	1:3105
Anglo Areas		
Van Nuys	167	1:793
Santa Monica	132	1:669
Bel Air	231	1:359
Beverly Hills	206	1:162

The California Court recognized that minorities have severe health problems. *Bakke* v. *Board of Regents,* 18 Cal. 3d 34, at 56. However, the Court noted neither the immense nature of the public health problem: sixteen critical shortage areas in Los Angeles County alone are largely minority; nor the geographical nature of the problem. It is the geographical nature of the problem that makes it all the more difficult.

Critical shortage areas is not just another social indicator that may apply to minorities in California like it applies to other people. Rather, in California urban areas, the over-whelming majority of *all* urban critical shortage areas are minority. This is what the California Court failed to understand and what com-

pels the amici into the case. Because only after the enormity of the health care problem among minorities is understood, can the immensity of the negative impact of an adverse decision on minorities be understood.

The urban health care availability crisis is not equally shared by the majority and minority population in California—it is to a great extent racial in nature.

This conclusion must be the first premise in analyzing the impact of the Court's decision on critical shortage areas. However, the California court largely ignored this fundamental point, merely concluding that minorities need health care. *Id.*

B. Urban Critical Shortage Areas Have a Greater Need for Primary Care Physicians Than Other Areas.

The California Health Manpower Policy Commission has recognized the greater need for primary care physicians in poverty areas by its application of a lower ratio of primary care physicians to population (1:1855) for geograhical areas in which the percentage of the population below the United State's Poverty Index exceeds 20 percent. *See* California Health Manpower Policy Commission, Third Annual Report to the California Legislature at 35 (1976).

A study conducted by the Los Angeles Hospital Commission found that for those persons who were classified as poor (i.e., eligible for Medi-Cal by the State of California Standards) the reported incidence of acute illness conditions was 67 percent higher than for persons in the non-poverty class.

A 1975 study revealed that the East Los Angeles Area Health District, a critical shortage area, when

compared with other area health districts, was first, second or third highest in the incidence of 23 of 24 diseases for which Los Angeles County was surveyed.

It would be redundant to provide a list of critical shortage areas in Los Angeles County that had a disproportionately high incidence of disease. Suffice it to say that a review of the data indicates that the list would be overwhelmingly minority. *See* Reportable Diseases, Los Angeles County (Records and Statistics Section, Department of Health Services, Los Angeles County, 1975).

The conclusion that critical shortage areas have a higher incidence of diseases is inescapable. The impact of this second premise was largely ignored by the California Court, which quoted statistics on minority health care problems without realizing their relationship to critical shortage areas. *Bakke, supra,* at 56.

While it is important that this group or that suffers deplorable health problems, these are not the fundamental health statistics which a Court should examine because they are, without more, irrelevant to this case. Although a group may have a high disease incidence, it does not necessarily mean that the group has a significantly limited access to health care, e.g., Tay-Sachs disease among Jewish people. But when high incidence of disease statistics are taken from critical shortage areas which are also minority, the statistics are significant for the proposition that people residing in these areas have an immediate unmet need for health care. The diseases themselves are caused by a variety of factors such as over-crowding and poor nutrition; however, treatment of disease is directly related to the availability of physicians. Critical shortage areas are un-

derserved because of the absence of primary care physicians. A plethora of federal and state statutes have made health care economically accessible to the poor and medically indigent. *See,* e.g., Medi-Cal Act Title XIX California Welfare and Institutions Code § 1400 et. seq.; Medicare, 42 U.S.C. § 1395; Medicaid, 42 U.S.C. § 1396; Hill Burton Act, 42 U.S.C. § 291 et. seq.; County Hospitals, Calif. Const. Article XIII § 21(1)(2)(3); National Health Planning Resources Development Act of 1974, 42 U.S.C. § 300(K).

However, care must also be geographically accessible for it to alleviate the health problems of persons residing in these areas. Amici agree with the California Court that it is not significant for the purposes of upholding minority admissions to merely recite deplorable minority health care statistics. However, these statistics are significant, if, as above, they are correlated to critical shortage areas which are predominantly minority and if race is a significant factor in a health care professional's decision to practice in such an area.

The Court below acceded to the fact that ". . . it is more likely that (minorities) will practice in minority communities than the average white doctor," but felt that minority admissions were not the most precise way to provide health professionals for minorities. *Bakke, supra* at 56.

This case must then turn on the following questions: Even if critical shortage areas for primary care physicians are disproportionately minority and have a disproportionately high incidence of disease, what evidence exists that minority admissions are the most

effective factor in meeting the minority health care problem?

C. Health Professional Graduates of California Minority Admissions Programs Practice in Minority Areas in Far Greater Proportion Than Their Peers.

The California Court concluded that "the University has not shown that the second major objective of the program—need for more doctors to serve the minority community—will be appreciably impaired," 18 Cal. 3d 34, 56. And in doing so the California Court pointed out that there was no empirical data to indicate that minorities are more socially oriented and less selfish than non-minorities. *Id.* Amici agree that such data would be difficult to develop; however, amici would further argue that the question is an inappropriate red herring. The issue is not what race is more selfless, but what selfless actions can be taken to provide adequate health care to all races. Moreover, the elimination of minority admissions would "appreciably impair" the flow of doctors to the minority communities because health professional graduates of California minority admissions programs have been shown to voluntarily practice in minority areas in far greater proportion than their Anglo peers.

A recently published study contained data showing that minority medical students are interested in practice in critical shortage areas at nearly double the rate of their Anglo peers shared such an interest. United States Department of Health, Education, and Welfare. *Student Indebtedness and Career Plans, 1974-75* (1976). This study reports the results of a national survey of medical students as to their career plans. The relevant question in this survey was "are you in-

terested in locating (other than to fulfill service commitment) in a critically underserved area?" Responses to this question showed that while only 45.6 percent of the Anglo students responded, "yes", fully 79 percent of Chicanos, Puerto Ricans, Blacks, and Native Americans answered "yes". Given the present extreme shortage of physicians in such critical shortage areas (reflecting the 98 percent Anglo physicians admitted to medical school prior to the late 1960's) the 45 percent *interest* rate among Anglo medical students would certainly be very different from the *actions* of Anglo medical students in the past. On the other hand, cited below is evidence that minority health professional students do in fact practice in critical shortage areas at a very high rate.

Ideally, amici would present data demonstrating the patient load by race of physician graduates of California minority admission programs; however, a significant number of minority medical students were not accepted in California medical schools through minority admission programs, or at all, prior to 1969. For example, not a single Chicano or Black was admitted to the University of California at Los Angeles Medical School from the time it was established in 1951 until 1966. Medical students attend medical school for four years and then, generally, gain an additional three to five years of residency training. There is thus, generally, a lag time of seven years between entry into medical school and completion of training. Thus, significant numbers of medical minority admission program graduates are only now completing their training and the number who have established their practices would be so small as to impair the validity of any conclusions that could be drawn from such a small universe.

On the other hand, dental students generally begin practice immediately subsequent to four years of dental school training. Minority students were also not admitted in significant numbers to dental schools in California prior to the late 1960's. For example, not a single Black person was admitted to the University of California at San Francisco Dental School between 1946 and 1967. Those minority students admitted to dental school in the late 1960's and early 1970's are thus now in practice. Because of the size of the available universe, the similarity in professions and the importance of dentistry in public health, data concerning minority graduates of dental school minority admissions programs is presented below.

The University of California at San Francisco Dental School recently conducted a survey as to practice location of minority dentists admitted to the school between 1969 and 1972 and thus graduated between 1973 and 1976. The University found that 75 percent of the minority dentists who had established practice (i.e., excluding those not in the military or in postgraduate training) were voluntarily practicing in minority areas. Dr. Luis Gonzales, "A Study of Practice Location of Graduates of Minority Admission Program at UCSF Dental School", 1973-1976 (1977) (unpublished study)

A larger study was completed in May, 1977 (and currently being prepared for publication) by Roberto Montoya, M.D., M.P.H. and Mr. Ed Smeloff of the California Department of Health.

The surveyors identified all minority graduates of the two public dental schools in California and one

private dental school: the University of California at San Francisco and the University of California at Los Angeles, and the University of Southern California. From 1969 to 1975, 108 minorities graduated from these three California schools: nine entered the armed services, thirteen left California, and five are affiliated as faculty with Schools of Dentistry. Of the eighty-one remaining dentists, forty-eight were located and interviewed, only two refused to respond.

As Table 4 clearly evidences, eighty-five percent of the minority graduates of minority admissions programs from three of California's four dental schools stated that their patients were predominantly minority. Moreover, fully thirty-seven percent of the minority graduates of minority admissions programs stated that 91-100 percent of their patients are minority.

TABLE 4

Percent of Minority Patients Served by Minority Graduates of Dental School Minority Admissions Programs

Percentage of Minority Patients Served	Number of Graduate Dentists	
0 - 9	2	
10 - 19	1	
20 - 29	1	
30 - 39	0	
40 - 49	3	
50 - 59	3	
60 - 69	5	
70 - 79	9	— 85%
80 - 89	5	
90 - 94	3	
95 - 100	14	
	46	

From the preceding sections it is evident that urban critical shortage areas for primary care physicians are nearly synonymous with barrios and ghettoes. It is patent that these areas have the greatest unmet health needs and the least available health resources. Non-minority graduates of previous years have, for numerous reasons chosen not to practice in these critical shortage areas. The California Department of Health cannot expect to protect the public health if sufficient health care professionals are unable or unwilling to practice in urban critical shortage areas. Minority admissions are vitally important to this Department's public charge—the protection of the California public health. An adverse decision will deprive this Department of a critical supply of health professionals who overwhelmingly choose to practice in critical shortage areas. Effects on the public health will be disastrous. Fiscal, social and health consequences will be severely felt in critical shortage areas for generations to come. Governmental attempts to protect the public health will be severely impaired by an adverse decision in this case.

The significance of these statistics to the public health system in California is great. It indicates that the importance of minority admissions programs to the minority community is far larger than had initially been suspected. Nearly nine out of ten minority graduates of dental admission programs are voluntarily treating minority patients at a rate more than double California's twenty-five percent minority population.

While it is important that these minority graduates of minority admissions programs serve minorities, one is compelled to recall Justice Douglas' dissenting

opinion in *Defunis* v. *Odegaard,* 416 US 312, at 342 (1973), relied upon by the California court:

> "The purpose of the University of Washington cannot be to produce black lawyers for blacks, Polish lawyers for Poles, Jewish lawyers for Jews, Irish lawyers for the Irish. It should be to produce good lawyers for Americans. . . ."

Amici concur that the purpose of health professional schools cannot be to train minority people. However, amici respectfully submit that, if the statement is to be more than a platitude, then the judiciary should not restrict constructive attempts by other branches of government to do their job and provide services to all Americans—including those Americans residing in urban critical shortage areas.

The statistics above are convincing evidence that minority health professionals are voluntarily returning to critical shortage areas because of the near identicalness between these areas and minority neighborhoods.

Even more convincing is an analysis of the office locations of the minority dental graduates of minority admissions programs who began practice in Los Angeles County. Nineteen dentists or 41 percent of those surveyed opened an office in Los Angeles County. Over 50 percent voluntarily located inside a critical shortage area. Thirty percent located in adjacent minority neighborhoods that are not considered critical shortage areas due in part to the presence of minority health professionals.

TABLE 5

Census Tract Location in Los Angeles County of Offices Established by Minority Graduates of Dental School Admissions Programs

Number	Census Tract Number	Description Area
1	2184	Critical Shortage Areas
1	2187	Critical Shortage Areas
2	5409.01	Critical Shortage Areas
1	2088	Critical Shortage Areas
1	2094	Critical Shortage Areas
1	5311	Critical Shortage Areas
1	5317.01	Critical Shortage Areas
1	4339	Critical Shortage Areas
1	5008	Critical Shortage Areas
1	2361	Minority Area Adjacent to CSA
1	2351	Minority Area Adjacent to CSA
1	6009.01	Minority Area Adjacent to CSA
1	6007.01	Minority Area Adjacent to CSA
1	6010	Minority Area Adjacent to CSA
1	4614	Non-minority
1	4636	Non-minority
1	2651	Non-minority
1	1914	Non-minority

Thus, eighty percent of the dental school graduates of minority admissions programs who are practicing in Los Angeles County have offices either in critical shortage areas or in minority areas immediately adjacent thereto.

Similarly, six minority graduates of minority admissions programs opened offices in Oakland, California. Five of the six located their offices in Black and Chicano ghettoes and barrios which have been desig-

nated "Federal critical health manpower shortage areas."

TABLE 6

Number	Census Tract	Area Description
2	4072	Federal critical health manpower area
2	4075	Federal critical health manpower area
1	4013	Defined as health manpower shortage area for purposes of the Health Maintenance Organization Act
1	4058	Not critical area

While other mechanisms may be devised to place health professionals in critical health manpower shortage areas, these mechanisms generally rely on some degree of coercion. Other mechanisms generally result in: (1) tremendous expenditures of public funds; (2) health professionals with less than voluntary attitudes, toward care for persons in these areas; (3) lack of continuity of care due to the fact that only a small percentage of involuntarily placed health professionals choose to remain in a critical shortage area after their period of service is completed.

In order to meet the need for health professionals in critical shortage areas, several Draconian actions have been proposed in state legislatures and the United States Congress—to the point of mandating all health professionals completing their training to be required to practice in such shortage areas for a specified length of time as a condition of acceptance into health professional schools.

In its decision in the present case, the California Supreme Court spoke in terms of less intrusive means to achieve the goal of increasing minority entrance into the medical profession. If this Court does not reverse the California decision, it may soon be faced with the prospect of dealing with actions which would be intrusive on the rights of all young health professionals to choose where and on whom they will practice.

Minority admissions programs, if encouraged, can be expected to obviate or diminish the need for government to consider such intrusions on the rights of young health professionals.

Amici are of the opinion that most important, long term, real and effective solution to the health care crisis in critical shortage areas is the training of health professionals who will *voluntarily* practice in these areas. Such persons have a high likelihood of establishing permanent practices and, over a period of years, develop the necessary rapport and knowledge of their patients—a necessary pre-requisite to long term, effective health care.

A majority of health professionals admitted via minority admissions programs have been shown to desire to, and more importantly, actually do practice in critical health shortage areas. If availability of health care in such areas is to be improved, a mechanism which has been shown to work voluntarily should be encouraged, rather than invite mechanisms which intrude on the rights of persons of all races.

This Court would be remiss if its action in this case did anything other than encourage successful, voluntary mechanisms as at the University of California, Davis Medical School; if it sustains, or makes more

restrictive the lower decision, it may very well invite actions or legislation that is more intrusive on the rights of persons of all races.

In summary, the California Court arrived at its decision on a series of assumptions concerning public health:

1. Minorities have deplorable health statistics but minority programs are not necessary to alleviate this unfortunate occurrence.
2. Minority doctors have a greater likelihood of practicing in minority neighborhoods than Anglo doctors, but this likelihood is not so substantial that the elimination of minority programs would impair efforts to serve minorities.
3. There are alternative means of selecting medical students willing to work in minority areas.

Bakke, supra, at 52-57

With regard to premise one, the California Court did not review available public data which would demonstrate the existence of critical shortage areas that are disproportionately minority. Incidence of disease are higher in these areas and there are few available health professionals. It is not the case that minorities are randomly distributed and that if minorities suffer disease due to socio-economic conditions they will have equal access to the health system as everyone else in their city. Neither minorities nor critical shortage areas are randomly distributed. Both show a remarkably high correlation. It is not the case that minorities can turn to the professionals "produced . . . for Americans" that

Justice Douglas referred to—because there are few doctors in critical shortage areas where doctors must be located to be geographically accessible. Minority admissions are not designed to produce minority physicians for minority people; they are designed to produce doctors for critical shortage areas and, therefore, to paraphrase Justice Douglas, good doctors for the American people.

With regard to premise two, the California Court could not have understood the extent to which the first section of its premise is an understatement. Minority medical students indicate a much greater desire to practice in critical shortage areas than do non-minority students. University and Department of Health studies indicate that graduates of minority programs in dental schools in California locate their practices in critical shortage areas or in other adjoining minority areas in overwhelming numbers. As Justice Tobriner noted in his Bakke dissent, California's minority programs are not producing minorities to treat only minorities, but the education of minorities is relevant to the provision of health care services to critical shortage areas. *See Id.* at 86.

With regard to premise three, absent a minority admissions program, none of the alternatives listed by the lower Court appear realistic for the purpose of providing health professionals to critical shortage areas in anywhere near the numbers of minority admissions. Most of the suggestions are currently utilized by medical schools, i.e., recruitment, courses concerning the poor and minorities. Other suggestions seem impractical and offer little hope for success, i.e., increased class size. More flexible admissions standards

are no panacea because minorities are not the majority of all the poor, rather minorities are a third of the poor. See U.S. Bureau of the Census, Statistical Abstract of the United States, at 415 Table 673 (1976). If current minority programs were changed to disadvantaged programs, one could fairly predict the elimination of over two-thirds of the current minority medical students by students who have shown far less inclination to practice in critical shortage areas. Minority admissions are a tried and proven highly efficient method of ultimately delivering health services to critical shortage areas. Minority admissions are the most efficient approach to the problem because: first, critical shortage areas are disproportionately minority; second, there is a high disease incidence suffered by people from critical shortage areas, who are predominantly minority; and third, it is minorities who overwhelmingly choose to practice in critically underserved areas. It is vitally important to the California health care system that this approach not be curtailed —because it is the only product on the market that works. The alternatives suggested by the lower court should be utilized in conjunction with minority admissions, but they are insufficient to replace minority admissions because they will not work alone. This Court learned long ago that where the problems of minorities are concerned, the nation cannot rely on mere good intentions, *see, e.g., Green* v. *County School Board,* 391 U.S. 430 (1968) (Freedom of choice plans that do not integrate ruled unconstitutional), rather it must rely on deliberate planning through affirmative action. *See, e.g., Swann* v. *Board of Education,* 402 U.S. 1 (1972).

This case is much akin to *Rodriguez* v. *Independent School District, supra,* in which this Court was called

upon to consider a lower court decision condemning the school finance system of Texas. Four other states had rendered similar decisions: California,[3] Minnesota,[4] Arizona,[5] New Jersey.[6]

The *Rodriguez* Court upheld the Texas school finance system when it became evident that the lower courts had relied on incorrect premises for their decisions. Similarly, the facts and figures in this case make the lower court's decision indefensible. The premises adopted by the lower court are clearly erroneous; they are wholly counter to the facts in the health field, and if accepted as true—without any supporting evidence—will have disastrous consequences on the California public health system.

Before the American judiciary rushes headlong into dismantling this vital part of the health care system, it is incumbent on the Courts to demand the evidence that will allow a full evaluation of the impact of its decisions. At stake here is far more than the right of one man to a constitutional cloak, *the rights of millions of people* residing in critical shortage areas hang in the balance. A decision adverse to minority admissions will exacerbate a health care crisis in minority underserved areas and will make it impossible for the Department to provide a minimally acceptable level of health care to minorities for decades to come. The

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[3] *Serrano* v. *Priest*, 5 Cal. 3rd 584, 487 P. 2d 1241, 96 Cal. Rptr. 601 (1971).

[4] *Van Ducartz* v. *Hatfield*, 334 F. Supp. 870 (D.Minn. 1971).

[5] *Hollins* v. *Shofstall*, No. C-253652 (Super. Ct. Ariz. Jan. 13, 1972).

[6] *Robinson* v. *Cahill*, 118 N.J. Super. 223, 2874 2nd 187 (1972).

tragic consequences to human life of such a decision are readily predictable: increased morbidity and mortality for real people.

II.

THE MINORITY ADMISSIONS PROGRAM UTILIZED BY PETITIONERS DOES NOT CONTRAVENE THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT.

A. Racial Classifications per se Are Not Unconstitutional

Amici contend that their use of racial classification and those of the University of California are not unconstitutional when used to promote integration and overcome past discrimination which adversely effects the health of the People of California. Racial classifications have been used not to deny equal protection but to secure the equal protection of the laws. *Swann* v. *Board of Education,* 402 U.S. 1 (1972); *San Francisco Unified School District* v. *Johnson,* 3 Cal. 3rd 937, 951 (1971). Amici has utilized race as a classification to conform to the mandates of the Federal Government, See e.g., Executive Order 11246 30 Fed. Reg. 12319, as amended 32 Fed. Reg. 14303, and the implementing regulations, 41 C.F.R. § 60.2 *et. seq.* The Amici has not utilized race to deny rights to the majority nor to minorities nor to exclude any racial group from full participation in the full utilization of their rights. In this application the Amici adhere to the court's rejection of the notion that the constitution is color-blind. *Swann* v. *Board of Education,* 402 U.S. 1 (1972); *Davis* v. *School Commr's of Mobile County,* 402 U.S. 33 (1971). Likewise, the Amici cannot be color-blind at the expense of disease and real deaths of people to whom we have a duty to protect. The Amici

do not argue on a theoretical plane. It is our doctors and our nurses who must heal the bodies of real people. Where will these healers come from if not from schools such as the petitioners?

Racial classifications when used to promote integration and overcome past discrimination and exclusion are not unconstitutional. Racial classification as utilized by the medical school do not fall within invidious racial classification nor do they serve to have a segregative and discriminatory effect, *e.g., Korematsu* v. *U.S.,* 323 U.S. 214 (1943); *Dunn* v. *Blumstein,* 405 U.S. 330 (1972) nor constitute discrimination through the utilization of a suspect classification. *See Loving* v. *Virginia,* 388 U.S. 1 (1967).

As Justice Tobriner emphasized "The racial classifications embodied in the special admissions are not intended to, nor do they, in fact, exclude any particular group from participation in the medical school; on the contrary, the program is aimed at assuring that qualified applicants of all racial groups are actually represented in the institution." *Bakke,* supra, at 68. In *Swann,* supra, the Court has recognized the utility of racial quotas as a meaningful tool to remedy the disultory effects of past de jure segregation and to promote integration.

B. The California Court Erred In Its Wooden Application of the Strict Scrutiny Test to a Program Designed to Remedy the Extreme Absence of Health Care in Critical Shortage Areas.

Though initially the Fourteenth Amendment was judicially limited to Blacks in the *Slaughter House Cases,* 83 U.S. (16 Wall.) 36, 81 (1873), by 1886 the Court in *Yick Wo* v. *Hopkins,* 118 U.S. 356, 369 (1886)

had extended the Fourteenth Amendment to Chinese.[7]

The Court has also made factual findings that Chicanos are an identifiable group for purposes of the fourteenth amendment stating:

> Throughout our history differences in race and color have defined easily identifiable groups which have at times required the aid of the courts in securing equal treatment under the laws. But community prejudices are not static, and from time to time other differences from the community norm may define other groups which need the same protection. Whether such a group exists within a community is a question of fact. When the existence of a distinct class is demonstrated, and it is further shown that the laws as written or as applied single out that class for different treatment not based on some reasonable classification, the guarantees of the Constitution have been violated. The Fourteenth Amendment is not directed solely against discrimination due to a "two-class theory" —that is, based upon differences between "white and Negro."[8]

Thus, the Court has extended the cloak of the Fourteenth Amendment to those requiring protection under either of the Court's tests: the less restrictive rational state interest and the more restrictive compelling state interest test. It is reasonably sure that the interests advanced by the state in the instant case could easily pass constitutional muster under the relaxed standard; however, it is highly unlikely that any governmental

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[7] *See Developments in the Law-Equal Protection*, 82 HARV. L. REV. 1065, 1126-1127 (1969) [hereinafter cited as *Developments-Equal Protection*].

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[8] *Hernandez* v. *Texas*, 347 U.S. 475 (1954).

activity could pass strict scrutiny in anything less than a national security situation. See *Korematsu* v. *United States, supra; cf.* Tussman and Ten Broek, *The Equal Protection of the Laws,* 37 CALIF. L. REV. 341, 374 (1949).

But while this Court has applied the strict scrutiny to racial classifications which are suspect, "identifiable groups" for purposes of the Fourteenth Amendment have possessed the following common characteristics:

1. Inalienable racial characteristics separating a group from the majority.
2. A stigma of opprobrium historically attached to the group by the majority.
3. Political impotence.

See Comment, THE EVOLUTION OF EQUAL PROTECTION-EDUCATION, MUNICIPAL SERVICES, AND WEALTH, 7, HARV. CIV. RTS.-CIV. LIB. L. REV. 103, at 132 (1972); *Developments-Equal Protection, supra* note 8, at 1127.

It is manifest that the characteristics evidence a special judicial solicitude for groups which the other branches of government might not sufficiently protect. Chief Justice Stone suggested this rationale in *United States* v. *Carolene Products Co.*[9]: "[P]rejudice against discrete and insular minorities may be a special condition which tends seriously to curtail the operation of those political processes ordinarily to be relied upon to protect minorities, and which may call for a correspondingly more searching judicial inquiry." Similarly in *Hobson* v. *Hansen,* 269 F. Suppl

[9] 304 U.S. 144, 153 n. 4 (1938).

401, 503 (D.D.C 1967) Judge Skelley Wright observed that the power structure "may incline to pay little heed to even the deserving interests of a politically voiceless and invisible minority."

One could hardly agree that the respondent in this case meets the rationale for which the strict scrutiny test evolved. Anglos are the majority in California and are neither voiceless nor politically impotent. All three branches of government in California are overwhelmingly Anglo. The necessity for judicial intervention in order to protect "a minority" in this case is non-existent. There is absolutely no reason to believe that the state legislative or executive branch has given less than full consideration to the interests of Anglo citizens.

Finally, the courts have long recognized the ability of other branches of government, and specifically educational authorities, to adequately represent majority Anglo interests in civil rights matters. In a string of cases, courts have denied white parents intervention into education cases, and nearly all deny intervention of right on the ground that existing party school boards adequately represent their interest. *See, e.g., Hatton* v. *County School Board,* 422 F. 2d 457 (6th Cir. 1970); *Hobson* v. *Hansen,* 44 F.R.D. 18 (D.D.C. 1968). The school board in this case is a Board of Regents which is overwhelmingly Anglo. Where the interests of the respondent can be presumed to be adequately represented by the existing authorities, as in the instant case, the strict scrutiny test is wholly inappropriate. There is no reason to believe that the Board of Regents was less than conscientious in representing the interests of Anglo citizens.

Moreover, the application of the strict scrutiny test to this case will result in the increased exclusion of "insular minorities" and the exacerbation of health care problem in critical shortage areas which are disproportionately inhabited by "insular minorities"—and all in the name of special judicial solicitude for the majority which controls the "offending" branches of state government. Such an interpretation would frustrate the purpose for which the strict scrutiny test evolved.

Amici must conclude that the California Supreme Court erred in its wooden application of an equal protection test that evolved in order to protect "insular minorities." The strict scrutiny test was applied in a manner that is anomalous with its original rationale: judicial protection of politically impotent minorities from abuses by the elected branches of government-legislative and executive.

CONCLUSION

Departments charged with protecting the health of the people of California were consulted by neither petitioner nor respondent as to the effect of this decision on the public health. Data analysis shows that critical shortage areas are disproportionately minority and that these areas also have higher incidences of disease. One could fairly conclude that critical shortage areas have the greatest unmet health needs and the least available health resources. Health professional graduates of California minority admissions programs practice in critical shortage areas in far greater proportion than their peers. While the Departments could debate the reasons for this phenomena, it is the fact

of its existence that is important. Minority admissions are a vital and necessary part of the health care delivery system. The Departments' ability to deliver adequate health services will be severely impaired by an adverse decision. The Departments cannot be expected to protect the public health if the judiciary deprives the Departments of a critical supply of health professionals who choose to practice in critical shortage areas. The California Court erred in its wooden application of the strict scrutiny test to a program designed to remedy the extreme absence of health care in critical shortage areas. Such an interpretation would frustrate the purpose for which the strict scrutiny test evolved. The amici do not argue on a theoretical plane, it is our doctors and our nurses who must heal the real bodies of real people, where will these healers come from if not from schools such as the petitioners?

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