June 19th, 2025

Anthony D. Archeval
Acting Director
HHS Office for Civil Rights
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
Sent Electronically: Anthony.archeval@hhs.gov

Re: Response to HHS Dear Colleague Letter on Nondiscrimination Requirements for Medical Schools

Dear Acting Director Archeval:

On behalf of the NAACP Legal Defense and Educational Fund, Inc. ("LDF"),[1] we are writing to express concerns regarding the recent "Dear Colleague Letter" issued by the U.S. Department of Health and Human Services (HHS) on May 6, 2025, titled "Nondiscrimination Requirements for Medical Schools on the Basis of Race, Color, and National Origin" ("Dear Colleague letter").[2] Ensuring access to the medical profession for qualified Black, Latino, white, Asian American, and Indigenous people benefits all patients by fostering culturally competent care, reducing implicit bias, and improving patient-provider communication. Yet your letter proposes a radical and inaccurate interpretation of federal law that risks increasing segregation and inequality in medical schools. Instead of encouraging medical schools to ensure greater equality, your letter threatens to cut funding to medical schools that address barriers to equal educational opportunities and create learning environments where all students can thrive, thus chilling lawful programs.[3] This directive is a dangerous regression of initiatives designed to ensure the health of all Americans and to close racial gaps in illness, mortality, and access to care. We urge you to rescind your Dear Colleague Letter, issued on May 6, 2025.

I. Persistent Racial Disparities in Health Care Due to Discrimination

[1] Founded in 1940 under the leadership of Thurgood Marshall, LDF's mission has always been transformative: to achieve racial justice, equality, and an inclusive society. Since the historic U.S. Supreme Court decision in *Brown v. Board of Education*, which LDF litigated and won, we have continued to represent Black students to ensure they receive quality and equitable educational opportunities.

[2] U.S. Dep't of Health and Human Services, Dear Colleague Letter: *Nondiscrimination Requirements for Medical Schools*, Office for Civil Rights (OCR), (May 6, 2025) (hereinafter "Dear Colleague Letter"), https://www.hhs.gov/sites/default/files/guidance-med-schools-dear-colleague-letter.pdf.

[3] Cohen et al.;*The case for diversity in the health care workforce*. Health Affairs, (2002). 21(5), 90–102, https://doi.org/10.1377/hlthaff.21.5.90.

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Black people in the United States suffer disproportionately from preventable diseases and early death.[4] Black people have higher rates of diabetes, hypertension, and heart disease than other racial groups. [5] Black infants die at a rate 2.3 times higher than white infants,[6] and Black children have a 500 percent higher death rate from asthma compared with white children.[7] In addition, Black women are three to four times more likely to die from pregnancy-related complications than white women,[8] and many of these deaths were preventable according to the CDC.[9] Many of these racial disparities persist even when accounting for socioeconomic status, lifestyle, insurance coverage, and other risk factors.[10]

While gaps in access to care[11] and disproportionate exposure to environmental hazards,[12] among other factors, contribute to these disparities, racial bias in the medical profession is also a driving force. Medicine is often inaccurately framed as an objective, rational, and scientific discipline, but the reality is that the medical profession is equally vulnerable to human flaws, including racial bias. In fact, racially disparate treatment by medical professionals is persistent and pervasive, as demonstrated in the HHS' 2021 National Health Care Quality and Disparities Report, which found that Black people received worse care than white people across 43 percent of 195 quality measures.[13]

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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] Risa Lavizzo-Mourey & David Williams, *Being Black Is Bad for Your Health,* U.S. NEWS (Apr. 14, 2016), https://www.usnews.com/opinion/blogs/policy-dose/articles/2016-04-14/theres-a-huge-health-equity-gap-between-whites-and-minorities.

[6]U.S. Dep't of Health & Human Svcs. Office of Minority Health, Infant Mortality and African Americans, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23#:~:text=Non%2DHispanic%20blacks%2FAfrican%20Americans,to%20non%2DHispanic%20white%20infants (last visited Sept. 23, 2022).

[7] Lavizzo-Mourey & Williams, *supra* note 56.

[8] DONNA L. HOYERT, CENTERS FOR DISEASE CONTROL, MATERNAL MORTALITY RATES IN THE UNITED STATES, 2020, https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm.

[9] Nada Hassanein, *'Staggering' and 'sobering': More than 80% of US maternal deaths are preventable, CDC study shows*, USA TODAY (Sept. 19, 2022 1:53 PM), https://www.usatoday.com/story/news/health/2022/09/19/cdc-us-maternal-deaths-preventable/10425271002/.

[10] *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).

[11] Predominantly Black, racially-isolated neighborhoods are more likely to be in primary care deserts and "offer fewer ambulatory facilities, more limited access to physicians, and a lower supply of surgeons." Mariana C. Arcaya & Alina Schnake-Mahl, *Health in the Segregated City,* NYU FURMAN CTR. (Oct. 2017), https://furmancenter.org/research/iri/essay/health-in-the-segregated-city

[12] Laura Wamsley, *Even many decades later, redlined areas see higher levels of air pollution*, NPR (Mar. 10, 2022), https://www.npr.org/2022/03/10/1085882933/redlining-pollution-racism; Daniel Cusick, *Past Racist "Redlining" Practices Increased Climate Burden on Minority Neighborhoods*, SCIENTIFIC AM. (Jan. 21, 2020), https://www.scientificamerican.com/article/past-racist-redlining-practices-increased-climate-burden-on-minority-neighborhoods/; OM SHAPIRO ET AL., LDF THURGOOD MARSHALL INST. & INST. ON ASSETS AND SOC. POL'Y AT BRANDEIS UNIV. THE BLACK-WHITE RACIAL WEALTH GAP 5 (2019), https://tminstituteldf.org/wp-content/uploads/2019/11/FINAL-RWG-Brief-v1.pdf.

[13] U.S. DEP'T OF HEALTH & HUMAN SERVS., AGENCY FOR HEALTHCARE RES. & QUALITY, 2021 NATIONAL HEALTHCARE QUALITY & DISPARITIES REPORT EXECUTIVE SUMMARY (2020), at ES–3, D–3–D–51, https:// www.ahrq.gov/sites/default/files/wysiwyg/research/ findings/nhqrdr/2021qdr.pdf.

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II. Racial Barriers to Medical Education for Underrepresented Groups

Ensuring equal access to medical education is a matter of fairness, as well as a public health imperative. In light of the well-documented racial bias in the practice of medicine, efforts to ensure equal opportunity for medical students of color "literally saves lives by ensuring that the Nation's increasingly diverse population will be served by healthcare professionals competent to meet its needs."[14] Research consistently demonstrates that a diverse physician workforce enhances communication, trust, and health outcomes, particularly for historically underserved populations.[15] When health care providers come from diverse racial and ethnic backgrounds, they bring unique cultural insights, reduce biases in care delivery, and are more likely to work in underserved areas. Yet racial barriers in medical education have long excluded talented students of color, limiting diversity within the health professions and reinforcing inequities in health outcomes. These barriers—such as biased admissions criteria, a lack of mentorship, underrepresentation in the faculty, and hostile learning environments—contribute to a medical workforce that does not accurately reflect the communities it serves. Addressing these structural barriers and promoting equitable access to the profession can help create a more responsive and inclusive healthcare system for all. By discouraging such equity initiatives, your guidance may hinder progress toward reducing health disparities, particularly in maternal health.

III. "Dear Colleague" Letters are a Mischaracterization of the Law

The Dear Colleague letter represents a radical misreading of civil rights law, including the Supreme Court's 2023 decision in *Students for Fair Admissions (SFFA) v. Harvard and the University of North Carolina (UNC)*. The letter is intentionally vague and misrepresents the law to target and chill institutions that believe diversity, equity, and inclusion are fundamental American values, thereby hindering their pursuit of legitimate efforts to promote equal opportunity. Your letter is incorrect in several respects:

- Your letter claims that diversity, equity, inclusion, and accessibility efforts are unlawful because they frequently involve racial preferences. However, these efforts are not preferences or quotas and often do not rely on decisions based on race. Lawful diversity, equity, inclusion, and accessibility programs include pathway programs that expose all students to medical careers and selective fields; broad outreach and recruitment measures to expand the applicant pool; voluntary affinity groups that any student can join; sexual harassment and antidiscrimination trainings; and mentoring programs that are open to all.

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[14] Br. for Amici Curiae Assoc. of Am. Med. Colleges, et al. in Support of Respondents, *Students For Fair Admissions, Inc. v. President & Fellows of Harvard College*, *Students For Fair Admissions, Inc. v. University Of North Carolina, et al.,* Nos. 20-1199 & 21-707 (Aug. 1, 2022), https://www.aamc.org/media/61976/download?attachment.

[15] Stanford FC. The Importance of Diversity and Inclusion in the Healthcare Workforce, J Natl Med Assoc. (Apr.23, 2020) doi: 10.1016/j.jnma.2020.03.014.

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- Your letter cites to the Supreme Court's decision in *SFFA* in the assertion that "broad concepts such as racial balancing and diversity"[16] are not a compelling interest that can justify race-conscious admissions policies. However, in *SFFA*, the Court reaffirmed that the benefits of diversity are "plainly worthy" and "commendable goals."[17] Moreover, the admissions policies at issue in *SFFA* were race-conscious because they explicitly considered race, as one factor of many, when making admissions decisions. But to the contrary, lawful diversity, equity, inclusion, and accessibility programs do not explicitly consider race when making decisions about an individual's access to resources or opportunities.

- Your letter claims that "while some programs may appear facially neutral, closer scrutiny may reveal that they function as proxies for race-based decision-making, which is inconsistent with federal law."[18] But reliance on facially neutral measures, in lieu of explicit race conscious measures, was precisely encouraged by the Supreme Court in *SFFA*[19]. Your letter ignores numerous cases finding that schools can use race-neutral measures to achieve diversity, equity, inclusion, and accessibility.[20] For example, schools can (1) consider socioeconomic status, (2) use geographic diversity (e.g., by zip code or feeder school), and (3) target under-resourced schools or first-generation students.

- Moreover, your Dear Colleague letter states that medical schools may not use students' personal essays, diversity statements, or other cues to determine or predict a student's race and favor or disfavor such students.[21] To the contrary, the Supreme Court made clear in *SFFA* that its decision did not "prohibit[. . .] universities from considering an applicant's discussion of how race affected his or her life, be it through discrimination, inspiration, or otherwise."[22]

Your Dear Colleague letter is the latest in a series of measures that have significantly restricted research and data collection about how to address critical health disparities, particularly regarding Black maternal health. Notably, the administration ended numerous National Institutes of Health grants dedicated to health equity research, including studies on Black maternal and fetal health.[23] These actions raise concerns among health advocates and researchers about the current administration's commitment to addressing longstanding disparities in maternal health outcomes. Additionally, the administration dismantled the Pregnancy Risk Assessment Monitoring System

[16] Dear Colleague at 2.
[17] *SFFA* at 213-214.
[18] *Id.*
[19] *SFFA* at 231
[20] *SFFA*
[21] Dear Colleague at 2.
[22] *SFFA,* 600 U.S.at 230.
[23] Protect Our Care, *It's A Bloodbath": Trump Administration Slashes Millions in NIH Funding for Maternal Health, HIV, and Other Research*, (Mar. 26, 2025), https://www.protectourcare.org/its-a-bloodbath-trump-administration-slashes-millions-in-nih-funding-for-maternal-health-hiv-and-other-research/

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(PRAMS), a vital program that had gathered data on maternal and infant health since 1988.[24] PRAMS was crucial in identifying disparities in health outcomes, especially among Black and Indigenous mothers and infants, and in guiding efforts to reduce maternal and infant mortality. This shift in federal health policy away from protecting all people have serious, long-term implications for the health and well-being of marginalized communities.

While your Dear Colleague letter criticizes many efforts designed to advance diversity, equity, inclusion, and accessibility, HHS OCR cannot rewrite Title VI and the Equal Protection Clause in its interpretations of those laws.[25] As an administrative guidance document, a Dear Colleague Letter should outline the Department's interpretation of existing civil rights statutes—specifically, Title VI—but cannot create new legal obligations or amend federal law or regulations. Courts are not bound by Dear Colleague letters, and institutions are not required to comply with interpretations beyond what is already mandated by statute or case law. Similar letters have faced legal challenges for misstating or overextending the law.[26]

IV. Conclusion

The health and well-being of all Americans is a critical precondition for the health of our economy and the success of our multiracial democracy. Accordingly, HHS OCR plays a vital role in ensuring the welfare of our country. However, as detailed above, your Dear Colleague Letter rolls back many initiatives and programs that seek to equalize opportunities and resources so that medical professionals and academic research can sufficiently address the most pressing health concerns among the most vulnerable populations. In light of these concerns, we urge HHS to rescind its Dear Colleague letter, issued on May 6, 2025.

Sincerely,

NAACP Legal Defense Fund Inc.

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[24] Repro Red Flags: Trump's First 100 Days, Center for Reproductive Rights, (2025) https://reproductiverights.org/agency-watch/100days/redflag2

[25] The Equal Protection Clause of the Fourteenth Amendment provides that no state shall "deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1.

[26] In NAACP v. U.S. Dep't of Education, the LDF filed a federal lawsuit on April 15, 2025, on behalf of the National Association for the Advancement of Colored People (NAACP) challenging the U.S. Department of Education's attempts to prohibit and chill lawful efforts to ensure that Black students are afforded equal educational opportunities through its "Dear Colleague" Letter on Feb. 14, followed by a "Frequently Asked Questions" document on Feb. 28 and a certification requirement on April 3 — all of which include factual inaccuracies and misinterpretations of civil rights laws and threaten the termination of critical public education funds.

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