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MEDICAL EDUCATION REVIEW

The ChangeMedED RoundTable Recommendations: Building a Bridge Beyond Race-Conscious Admissions Policies to Equitable Outcomes in Education and Health After the Supreme Court's Decision in SFFA

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ABSTRACT

In response to the uncertainty triggered by the 2023 U.S. Supreme Court (SCOTUS) decision in Students for Fair Admissions (SFFA) vs. Harvard and the University of North Carolina (UNC),[1] the Medical Education Unit of the American Medical Association brought together a group of thought leaders in medical education. The group — named the ChangeMedEd RoundTable — participated in a year-long consensus process to define steps that organized medicine might take to support medical education to improve health outcomes across all communities. Over the course of four meetings (three virtual and one final in-person), the group developed a set of recommendations across six categories: Data Standards; Research; Policy, Legislative Advocacy and Funding; Curriculum, Evaluation and Assessment; Accreditation and Accountability; and Physician Workforce. The group developed numerous strategies to support each recommendation. The recommendations are offered as guidance to medical education to accelerate its ongoing march toward optimizing health outcomes across all communities.

The role of medical education is to produce a physician workforce that meets the needs of society by providing high-quality care to all patients, thus improving community health. Yet the U.S. has some of the worst health outcomes among our peer nations,[2] with strikingly divergent outcomes in rural areas and other disadvantaged communities.[3] Moreover, our nation faces a projected physician shortage of over 130,000 physicians by 2030,[4] which will negatively impact underserved communities. The lack of heterogeneity in the physician workforce will further deepen the public health crisis based on studies showing that racial, language, and cultural congruity improve patient outcomes.[5-7] Additionally, students from underserved communities are more likely than others to practice in those areas; however,

a The thoughts and ideas expressed in this article are those of the authors and should not be assumed to represent official AMA policy or that of authors' institutions.

they face significant hurdles to enter and succeed in medical education.[8] While many social determinants and structures have a greater impact on health than direct care delivery,[9] the composition of the physician workforce falls squarely within medical education's control. Medical education receives substantial public support, with Medicare contributing over $16 billion to graduate medical education programs in 2020.[10]

While education of the workforce is in the public domain, there are significant headwinds to creating the workforce that can improve the health care of all. The 2023 U.S. Supreme Court (SCOTUS) decision in Students for Fair Admissions (SFFA) vs. Harvard and the University of North Carolina banning the use of race in admissions, uprooted half a century of policies that helped institutions across the country diversify not only their student populations, but faculty and staff as well.[1] More recently, growing federal and state "anti-DEI" efforts have sown fear and confusion, further exacerbating the public health crisis and concerns about fair educational opportunities. These changes are stifling medical education's attempts to expand workforce participation and create learning environments that support the success of all learners.

Creation of the RoundTable Recommendations

After the SCOTUS decision, starting in the fall of 2023, the Medical Education Unit of the American Medical Association brought together 30 thought leaders from undergraduate medical education (UME), graduate medical education (GME), and organized medicine to engage in a year-long discussion focused on fairness in medical education. Seven medical organizations and 15 medical schools were represented. The goal was to develop a set of recommendations to advance health and wellness in the aftermath of the Supreme Court's decision in *SFFA* and define steps that organized medicine might take to support medical education efforts to optimize health outcomes across all communities.

This inquiry guided the group's deliberations over four meetings (three virtual and the final in-person), resulting in the creation of six recommendations, each supported by specific strategies. A final poll established consensus that participants felt heard, that the process was fair and that they were satisfied with the outcomes. The full set of recommendations, including accompanying strategies, can be accessed here. Some updates and clarifications were added in the writing of this summary paper. What follows is a summary of each recommendation and the associated strategies.

RECOMMENDATION I: Data Standards

Establish uniform qualitative and quantitative data standards for ongoing reporting to enable meaningful research, enhance interoperability, and promote collaboration.

Data standards are guidelines for ensuring consistency, accuracy, and interoperability of educational and health information leading to more accurate and consistent data across different systems and institutions — a concept known as semantic interoperability. This is vital for medical education as it allows for the integration of a variety of data sets for analysis and learning. When different groups have dissimilar measurements, comparison across institutions is problematic.

Currently, while medical schools and residencies perform similar tasks of training physicians, there is no uniform measurement system. For example, demographic data come from multiple sources, including the American Medical College Application Services (AMCAS) application, student self-disclosed demographics, assumptions made by residency programs, or other sources. Further, the methods of categorizing trainees have changed over the past decade, including whether an individual can self-identify in several categories, what categories are available, and whether self-description is an option. To effectively interrogate and monitor medical education, we need to institute data standards to assist in understanding our educational context.

The RoundTable Recommendations call upon broad collaboration between national organizations associated with medical education, including but not limited to, professional associations, accreditation agencies (e.g., Liaison Committee on Medical Education [LCME], Committee on Osteopathic Accreditation [COCA], Accreditation Council for Graduate Medical Education [ACGME]), and those associated with selection and assessment, e.g., Association of American Medical Colleges [AAMC], National Board of Medical Examiners [NBME]). A common set of data standards would support the longitudinal tracking of learners/physicians across the trajectory of their professional engagements and contribute substantively to the identification of characteristics that might be associated with specific outcomes, e.g., practice in underserved communities and discipline choice. Over time such predictive metrics could facilitate the identification of "what really matters" in medicine and help transform UME and GME selection to processes that are more outcomes-focused. Such data analysis could challenge conventional perspectives of perceived merit to center on skills, attributes, and accomplishments that make meaningful and measurable differences in the lives of patients and communities.

RECOMMENDATION II: Research

Fund education and health outcomes-based research to drive innovation in developing the workforce needed to optimize health outcomes across all communities.

Medical education research is needed to deepen the understanding of learning, curriculum, educational environment, and assessment in medicine, ultimately to improve the quality of medical training. The result should be

to improve the future capabilities of health care professionals to enhance patient care and public health. Importantly, this includes training medical professionals from different backgrounds to care for all patients and communities. Thus, research into the process of educating physicians to determine whether the educational system is achieving the goals desired is needed. As an example, research into barriers preventing disadvantaged students from entering and completing medical school is vital for strengthening the physician workforce. This includes addressing issues like access, socioeconomic disadvantages, social barriers, unequal opportunity, and lack of support, ultimately leading to a physician workforce better suited to meet the needs of all communities.

Recent changes in directives from the Department of Education, more stringent limits on student borrowing, as well as withdrawal of National Institutes of Health funding for certain categories of research that have occurred in the wake of the SCOTUS holding that race-conscious admissions policies violate the constitution have created a confusing and unstable landscape for learners, faculty, and institutions. In her dissent in *SFFA*, Justice Ketanji Brown Jackson wrote, "deeming race irrelevant in law does not make it so in life."[11] Her statement acknowledges the ongoing impact of longstanding systemic issues that the loss of race-conscious admissions policies will only exacerbate. It is now more important than ever to engage in research that documents the impact of the loss of race-conscious tools on the enrollment and attrition of learners in medical education, the subsequent composition and distribution of the health care workforce, and ultimately patient outcomes. The absence of reliable data and sound analysis constrains our capacity to engage in fact-based dialogue and decision-making.

Recommendation III: Policy, Legislative Advocacy, and Funding

The AMA, in collaboration with other relevant stakeholder organizations, should engage in advocacy for funding, incentive structures, and policy development to optimize health outcomes across all communities — reinforcing the perspective that, "all policy is health policy." It will elevate the status of health care as a vital national interest to facilitate improved health outcomes, coherent and continuous learning, and professional development across the educational continuum (from UME to practice).

The 2023 SCOTUS majority decision in SFFA noted an amicus curiae brief that contended race-based admissions programs further compelling interests at our nation's military academies.[1] However, the court did not rule on this issue. It is notable that at over 1.1 million, the number of Americans who have died from COVID[12] is far greater than the total number of U.S. soldiers who have died in major conflicts since the Civil War.[13] The obvious question is whether race-based admissions represent a compelling interest in health care education as well? The COVID-19 pandemic disrupted multiple sectors, including the economy, education, transportation, and even international

relations, just to name a few.[14] Therefore, one potential approach to addressing the widening gap in discrepant health outcomes could be to adopt national, regional, and local "health in all policies"[15,16] framework, necessitating cross-sectoral advocacy at all these levels. This issue is relevant to the overall conduct of medical education across the continuum from UME to practice, as well as the delivery of health care to individuals and communities.

The RoundTable Recommendations call for collaboration across a broad range of national groups (e.g., AMA, AAMC, and ACGME as well as groups such as the National Academy of Medicine) to advocate for the development of the National Health Workforce Commission,[17] which was proposed in the Affordable Care Act as a mechanism for developing a national health care workforce strategy, but never funded. Policy recommendations from such a body could help elevate debates related to admissions policies and specialty choice currently focused on individual learners to emphasize the agency of underserved patients and communities. It could also provide guidance in navigating the intersection of the funding support for medical education, physician reimbursement, and the specialty distribution of the physician workforce, which are all specifically explored in separate recommendations.

The recommendations also suggest increased efforts to broaden the funding support for programs and initiatives that expand access to education. This has increased relevance given the abrupt cancellation of federal support for such programs since the 2024 presidential election.[18] Lastly, the structure of medical education aligns with its funding, with UME being primarily tuition-driven and GME supported by a combination of dollars from Medicare, Medicaid, and Veterans Affairs.[19] The structure of the funding contributes to a discontinuous learning experience. The recommendations challenge us to reimagine funding sources with educational continuity as a goal.

RECOMMENDATION IV: Curriculum, Evaluation, and Assessment

Each institution should ensure curriculum, teaching methods, and faculty development support an accessible learning and clinical environment. Assessment and evaluation should emphasize competency and foster the success of all learners.

The modern structure and function of medical education was established by the Flexner Report in 1910.[20] One purpose of this reform was to standardize medical education and place it on sound scientific footing. Another purpose was to elevate the status of the profession. It recommended the closure of all the women's medical schools, and five of the seven existing Black medical schools, leaving only the schools at Meharry and Howard Universities.[20] It also suggested that Black men be trained as sanitarians.[20] The Flexner Report recommended a college education as an entry requirement. These recommendations and others made the profession of medicine the province

of wealthy white men primarily from the Northeast, the region of our nation that still has the highest concentration of medical schools over a century later. Much has changed in the past 115 years, and medical education cannot afford to remain in the early 20th century. With the growing evidence of the positive impact of participation by students from different backgrounds in education environments and the physician workforce,[21-25] modern medical education environments must support the learning needs and success of all learners.

The RoundTable Recommendations suggest that medical schools work diligently to identify what matters in medical education and learning. From the perspective of curriculum, the recommendations support alignment of medical school curriculum to AAMC Diversity, Equity, and Inclusion Competencies Across the Learning Continuum[26] and tie learner assessment to specific competencies by promoting competency-based medical education (CBME) and accessibility through broad adoption of technological resources throughout the learning environment. Specifically, in the near-term, medical schools should develop strategies to eliminate differential access to the resources available to students to prepare for standardized tests, as well as identify and address discrepant outcomes in standardized testing, clinical assessments, and the underlying causes. In the longer term, competency assessment should drive promotion across UME and GME as well as faculty promotion. Additionally, schools should collaborate to identify and disseminate best practices for accommodating disabilities.

RECOMMENDATION V: Accreditation and Accountability

Ensure accreditation prioritizes and supports institutional mission alignment with national and community-informed health enhancement goals, paying close attention to discrepant outcomes across all areas.

Accreditation plays a pivotal role in education at all levels by establishing specific standards to ensure the quality of teaching and learning. At the level of medical education, the LCME[27] promotes quality assurance and accredits MD-granting schools. The American Osteopathic Association's Commission on Osteopathic College Accreditation (COCA)[28] serves the same role for DO-granting schools. The ACGME[29] oversees graduate medical education. At the level of medical education, accreditation can also promote improved health outcomes by supporting continuous quality improvement through curricular change, improvements in the learning environment, and attainment of competencies aligned with the needs of all patients and communities.[30,31] It is in this capacity that accreditation can provide critical support to medical education at this pivotal time as it faces many intrusive and evolving challenges in the wake of the loss of race-conscious admissions policies, as well as threats to funding and restrictions in some states on specific elements of teaching and training.[32-35]

It can be argued that optimal health for all is a primary goal of medical education. The recommendations call for a shift in focus of accreditation to outcomes. These can be outcomes that align with an institution's self-determined mission. As an example, some public schools have a mandate to develop a workforce to serve the citizens of the state or to address local or regional health needs. The role of the accreditor then could be to support and monitor quality improvement of meaningfully crafted curricula and alignment with measurable, institutionally determined outcomes. Another role could be to support the ongoing development of goals to optimize health outcomes informed by community input and progress toward achievement demonstrated by rigorous data collection and analysis.

RECOMMENDATION VI: Physician Workforce

Establish the responsibility of medical education and academic health centers for preparing the health workforce to optimize health outcomes across all communities.

The organizations overseeing medical education must urgently work together to broadly define a national mission for medical education that prioritizes improved patient outcomes across all communities. This will require reaching consensus on what policies and practices are most relevant to informing selection, transforming assessments, and promoting retention to achieve the goal of producing a physician workforce that can meet the health care needs of our society. Deliberations on developing a broad social mission for medical education should include the voices of the National Academy of Medicine and the National Healthcare Workforce Commission (if it is established) along with previously excluded physician groups, medical student groups, and patients.

Graduate education is part of a continuum of teaching and learning that begins prior to kindergarten. K-12 education remains separate and unequal, due primarily to residential segregation and funding mechanisms, mainly local property taxes.[36] Gaps exist in student achievement across multiple curricular elements. To improve the K-12 pathway, the recommendations suggest advocacy for state-level support of public education.

Additionally, the recommendations call for development of strategies in recruitment, selection and retention in graduate medical education that support completion of training. The attrition documented in the K-12 pathway also occurs in undergraduate and graduate programs.[37] However, as early childhood education can improve academic success in the K-12 pathway, there are strategies that can bolster achievement in undergraduate and graduate education.[38,39] Achieving this goal in medical education will require collaboration by the organizations with responsibility for the

oversight of UME and GME, e.g., AMA, AAMC, ACGME, LCME, and COCA. Such collaboration will greatly support the aspiration to develop a workforce capable of optimizing health outcomes across all communities.

The current state, post SCOTUS Decision

The loss of race-conscious admissions policies has clearly been disruptive. However, in recent years its overall effectiveness has been questioned. A 2021 study projected that at the slow pace of expansion of participation in GME by people reflective of community demographics, depending on the specialty, it would take 35 to 93 years to reach parity with the general population.[40] Additionally, in a recent study of matriculation to medical schools in 2024, the enrollment of students from traditionally disadvantaged communities declined 3.56%.[41] This was interpreted as a direct result of the *SFFA* decision because enrollment declines were not seen in schools in states with prior bans on the consideration of race in admissions. The study suggests that the loss of this tool is having a negative impact on efforts to expand participation in medical education. Since *SFFA* was decided, through a series of executive orders and policy statements, we have also experienced evolving changes in education policy and funding that challenge the ability of medical education to engage in appropriate workforce development to foster responsive health care delivery. It is not hyperbole to state that the capacity to create a physician workforce that is broadly representative of the population of our nation is in jeopardy now more than at any other time in the past half century. This is the challenge that confronts medical education today. How do we respond in ways that expand the ability of medical education to train a physician workforce inclusive of individuals with varied lived experiences that can provide excellent care to all patients and communities?

Conclusions

While no set of recommendations can ever be totally comprehensive, the ChangeMedEd RoundTable Recommendations do provide a starting point for a much-needed, honest, deliberative, and data-informed conversation on how the organizations that comprise the house of medicine can support the mission of medical education. The six domains of recommendations represent important elements of the structure and function of medical education that would benefit greatly from supportive engagement by oversight organizations. Despite the decision in *SFFA*, the mission of medical education must remain the production of a workforce capable of meeting the needs of not just some, but all our fellow citizens. *SFFA* banned the consideration of race in admissions. However, in the majority decision, Chief Justice Roberts explicitly stated, "nothing prohibits universities from considering an applicant's discussion of how race affected the applicant's life, so long as that discussion is concretely tied to a quality of character or unique ability that the particular applicant can contribute to the university."[1] While the current moment presents many obstacles to progress, the loss of race-

conscious admissions also presents opportunities to develop new structures, practices, and processes that are more durable and more effective to further medical education's vital mission. We should capitalize on this potential opportunity with all deliberate speed. Fairness, justice, and most of all our patients, demand nothing less.

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REFERENCES

1. Supreme Court of the United States. Students for Fair Admissions, inc v. President and Fellows of Harvard College. https://www.supremecourt.gov/opinions/22pdf/20-1199_hgdj.pdf

2. Mirror, Mirror 2024: A Portrait of the Failing US Health System. https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024

3. Deeply Entrenched Racial and Geographic Health Disparities in the USA have Increased Over the Last Two Years. https://www.healthdata.org/news-events/newsroom/news-releases/lancet-deeply-entrenched-racial-and-geographic-health

4. Zhang X, Lin D, Pforsich H, Lin VW. Physician workforce in the United States of America: forecasting nationwide shortages. *Hum Resour Health*. 2020;18(1):8. doi:10.1186/s12960-020-0448-3

5. Saha S, Shipman SA. Race-neutral versus race-conscious workforce policy to improve access to care. *Health Aff (Millwood)*. 2008;27(1):234-245. doi:10.1377/hlthaff.27.1.234. PMID:18180500

6. Cano-Ibáñez N, Zolfaghari Y, Amezcua-Prieto C, Khan KS. Physician-Patient Language Discordance and Poor Health Outcomes: A Systematic Scoping Review. *Front Public Health*. 2021;9:629041. doi:10.3389/fpubh.2021.629041. PMID:33816420

7. Shen MJ, Peterson EB, Costas-Muñiz R, et al. The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature. *J Racial Ethn Health Disparities*. 2018;5(1):117-140. doi:10.1007/s40615-017-0350-4. PMID:28275996

8. Walker KO, Moreno G, Grumbach K. The association among specialty, race, ethnicity, and practice location among California physicians in diverse specialties. *J Natl Med Assoc*. 2012;104(1-2):46-52. doi:10.1016/s0027-9684(15)30126-7. PMID:22708247

9. Greer ML, Garza MY, Sample S, Bhattacharyya S. Social Determinants of Health Data Quality at Different Levels of Geographic Detail. *Stud Health Technol Inform*. 2023;302:217-221. doi:10.3233/SHTI230106. PMID:37203650

10. Medicare Graduate Medical Education Payments: An Overview. https://crsreports.congress.gov/product/pdf/IF/IF10960

11. The Decision That Upends the Equal-Protection Clause. https://www.theatlantic.com/ideas/archive/2023/06/scotus-affirmative-action-ruling-implications/674567/

12. COVID-19 Deaths by Selective Demographic and Geographic Characteristics. https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm

13. American War and Military Operations Casualties: Lists and Statistics. https://www.congress.gov/crs-product/RL32492

14. Nicola M, Alsafi Z, Sohrabi C, et al. The socio-economic implications of the coronavirus pandemic (COVID-19): A review. *Int J Surg*. 2020;78:185-193. doi:10.1016/j.ijsu.2020.04.018. PMID:32305533

15. Green L, Ashton K, Bellis MA, Clemens T, Douglas M. 'Health in All Policies'-A Key Driver for Health and Well-Being in a Post-COVID-19 Pandemic World. *Int J Environ Res Public Health*. 2021;18(18):9468. doi:10.3390/ijerph18189468. PMID:34574390

16. Promoting. Health in All Policies and Intersectoral Action Capacities. https://www.who.int/activities/promoting-health-in-all-policies-and-intersectoral-action-capacities

17. PI, Retchin SM. The dormant National Health Care Workforce Commission needs congressional funding to fulfill its promise. *Health Aff (Millwood)*. 2013;32(11):2021-2024. doi:10.1377/hlthaff.2013.0385. PMID:24191095

18. Ending Illegal Discrinination and Restoring Merit-Based Opportunity. https://www.whitehouse.gov/presidential-actions/2025/01/ending-illegal-discrimination-and-restoring-merit-based-opportunity/

19. Varvares M, Zeitouni JF, Gray S. Should Private Equity Firms Own Residency Slots? *AMA J Ethics*. 2025;27(5):E325-332. doi:10.1001/amajethics.2025.325

20. The Flexner Report. http://archive.carnegiefoundation.org/publications/pdfs/elibrary/Carnegie_Flexner_Report.pdf

21. Snyder JE, Upton RD, Hassett TC, Lee H, Nouri Z, Dill M. Black Representation in the Primary Care Physician Workforce and Its Association With Population Life Expectancy and Mortality Rates in the US. *JAMA Netw Open*. 2023;6(4):e236687. doi:10.1001/jamanetworkopen.2023.6687

22. Saha S, Shipman SA. Race-neutral versus race-conscious workforce policy to improve access to care. *Health Aff (Millwood)*. 2008;27(1):234-245. doi:10.1377/hlthaff.27.1.234. PMID:18180500

23. Shen MJ, Peterson EB, Costas-Muñiz R, et al. The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature. *J Racial Ethn Health Disparities*. 2018;5(1):117-140. doi:10.1007/s40615-017-0350-4. PMID:28275996

24. Walker KO, Moreno G, Grumbach K. The association among specialty, race, ethnicity, and practice location among California physicians in diverse specialties. *J Natl Med Assoc*. 2012;104(1-2):46-52. doi:10.1016/s0027-9684(15)30126-7. PMID:22708247

25. Salhi RA, Dupati A, Burkhardt JC. Interest in Serving the Underserved: Role of Race, Gender, and Medical Specialty Plans. *Health Equity*. 2022;6(1):933-941. doi:10.1089/heq.2022.0064. PMID:36636113

26. Diversity, Equity, and Inclusion Competencies Across the Learning Continuum. https://store.aamc.org/downloadable/download/link/id/MC4zMzA1MTgwMCAxNjU3ODM1NTg1MTQxNTg3NTkxNTU0OTE0NDI%2C

27. Liaison Committee on Medical Education: LCME. https://lcme.org/publications/

28. Commission on Osteopathic College Accreditation. https://osteopathic.org/accreditation/standards/

29. Accreditation Council on Graduate Medical Education. https://www.acgme.org/

30. Frank JR, Taber S, van Zanten M, et al. The role of accreditation in 21st century health professions education: report of an International Consensus Group. *BMC Med Educ*. 2020;20(Suppl 1):305. doi:10.1186/s12909-020-02121-5

31. Arja SB, White BA, Fayyaz J, Thompson A. The impact of accreditation on continuous quality improvement process in undergraduate medical education programs: A scoping review. *MedEdPublish*. 2024;14:13. doi:10.12688/mep.20142.2. PMID:38800136

32. Proposed Changes to Federal Student Loans Could Worsen the Doctor Shortage. https://www.aamc.org/news/proposed-changes-federal-student-loans-could-worsen-doctor-shortage

33. Ending Wasteful Government DEI Programs and Preferencing. https://www.whitehouse.gov/presidential-actions/2025/01/ending-radical-and-wasteful-government-dei-programs-and-preferencing/

34. Jackson M (Jai). The Impact of Anti-DEI Legislation on Higher Education Pedagogy. *Journal of College and Character*. 2025;26(1):61-73. doi:10.1080/2194587X.2024.2442717

35. President Donald J. Trump Reforms Accreditation to Strengthen Higher Education. https://www.whitehouse.gov/fact-sheets/2025/04/fact-sheet-president-donald-j-trump-reforms-accreditation-to-strengthen-higher-education/

36. 70 years after Brown v. Board of Education, new research shows rise in school segregation. https://ed.stanford.edu/news/70-years-after-brown-v-board-education-new-research-shows-rise-school-segregation

37. Bustamante AS, Bermudez VN, Ochoa KD, Belgrave AB, Vandell DL. Quality of early childcare and education predicts high school STEM achievement for students from low-income backgrounds. *Dev Psychol*. 2023;59(8):1440-1451. doi:10.1037/dev0001546. PMID:37326529

38. Green SL, Wright CF. Retaining First Generation Underrepresented Minority Students: A Struggle For Higher Education. *Journal of Education Research*. 2017;11(3):323.

39. Wilson M, DePass A, Bean A. Institutional Interventions That Remove Barriers to Recruit and Retain Diverse Biomedical PhD Students. Published online May 11, 2018. doi:10.1187/cbe.17-09-0210

40. Bennett CL, Yiadom MYA, Baker O, et al. Examining Parity among Black and Hispanic Resident Physicians. *J GEN INTERN MED*. 2021;36:1722-1725. doi:10.1007/s11606-021-06650-7

41. Nguyen M, Hajduk AM, Fancher TL, et al. Medical School Admissions After the Supreme Court's 2023 Affirmative Action Ruling. *JAMA Netw Open*. 2025;8(8):e2527008. doi:10.1001/jamanetworkopen.2025.27008