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2003]

INFECTED JUDGMENT: LEGAL RESPONSES TO PHYSICIAN BIAS

MARY CROSSLEY*

Over the course of more than two decades, a physician prescribed daily insulin injections for an African-American woman with diabetes. The physician prescribed only one injection per day for the woman, despite accumulating medical evidence that two or even more injections per day would better control the diabetes. The physician did not order additional injections, though, because he was concerned that the patient would not comply with a more demanding treatment regimen. As a result of the failure to control her diabetes, the patient ultimately lost both her legs below the knee to amputation.¹

A woman visits a gynecologist for her annual exam. In response to the physician's questions during the exam, the woman discloses that she is a lesbian. The physician becomes visibly nervous, but completes the physical exam. He fails, however, to order the standard Papanicolaou test, perhaps believing (erroneously) that lesbians do not need the same regular gynecologic screening that heterosexual women receive.²

An overweight woman consults her doctor about her inability to become pregnant. He recommends that she lose weight, so she loses twenty pounds. The doctor continues to attribute her infertility to her weight and refuses to do any tests on her or her husband to identify other possible causes of infertility. Another gynecologist whom the woman consults determines that the

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1. *Diabetes Treatments Lag for Minorities*, *Health Officials Note*, BALTIMORE SUN, Mar. 27, 2001; cf. MARIAN E. GORNICK, VULNERABLE POPULATIONS AND MEDICARE SERVICES: WHY DO DISPARITIES EXIST? 43 (2000) (noting that physicians may believe that minority patients are more likely to misunderstand complex information and less likely to adhere to doctor's orders); see Michelle van Ryn & Jane Burke, *The Effect of Patient Race and Socio-economic Status on Physicians' Perceptions of Patients*, 50 SOC. SCI. & MED. 813, 821 (1997) (finding that physicians tended to perceive black patients as being at risk for noncompliance).

2. *AMA Council on Scientific Affairs, Health Care Needs of Gay Men and Lesbians in the United States*, 275 JAMA 1354, 1355 (1996) [hereinafter *Health Care Needs*] (according to survey of lesbians, some physicians respond negatively when they disclose their sexuality and some physicians omit routine gynecological tests for lesbian patients that are otherwise performed for heterosexual patients).

couple's infertility is the result of the husband's low sperm count. Following artificial insemination, the woman has an unremarkable pregnancy.³

I. INTRODUCTION

WHAT do these stories share in common? Each involves a situation in which a personal characteristic of a patient seeking medical advice or treatment appears to have influenced a physician's clinical treatment of the patient. In each case, the physician's medical judgment regarding what diagnostic intervention or treatment is appropriate for the patient appears to be affected, or biased, by a personal characteristic of the patient that may be irrelevant to the patient's medical needs. Physician bias based on clinically irrelevant patient characteristics and possible legal responses to biased medical decisions are the subjects of this Article.

Several negative effects may flow from the operation of bias in physicians' clinical decision making, particularly if the patient perceives the bias. In addition to stirring feelings of betrayal and injustice, the patient's perception of biased treatment recommendations will likely result in the patient's loss of trust in the physician. A patient's trust in his physician to act in the patient's best interest is an essential ingredient in the therapeutic relationship.⁴ This trust allows him to share private information that may relate to his medical needs and to rely on the physician's expert advice regarding diagnosis and treatment. Indeed, the trust may even affect the effectiveness of the treatment provided. Thus, the loss of trust in a particular clinical encounter that may result from biased medical decision making (or even the mere perception of bias) can negatively affect the physician's ability to successfully address the patient's medical needs.

The very operation of a bias that influences the physician's medical judgment may also have an adverse effect on the patient's well being. If a personal characteristic of the patient unrelated to the patient's medical needs influences the physician's choice of therapeutic intervention, then the physician's decision may reflect an inaccurate assessment of what intervention is optimal. Being biased by a clinically irrelevant trait, the physician's judgment may lead to an intervention that fails to provide the patient with her best opportunity for a good outcome—whether that be survival, cure, an accurate diagnosis or simply comfort.

3. Leanne Joannis, *Fat Bias in the Delivery of Health Care* 10 (1999) (unpublished manuscript, on file with author) (citing D. Burgard & P. Lyons, *Alternatives in Obesity Treatment: Focusing on Health for Fat Women*, in *FEMINIST PERSPECTIVES ON EATING DISORDERS* 212 (P. Fallon et al. eds., 1994)).

4. See Mark A. Hall, *Arrow on Trust*, 26 J. HEALTH POL. POL'Y & L. 1131, 1134 (2001) ("Preserving the psychology of trust in the core physician-patient relationship is essential to the efficacy of medicine."); Frances H. Miller, *Trusting Doctors: Tricky Business When it Comes to Clinical Research*, 81 B.U. L. REV. 423, 426 (2001) ("Trust has always been deemed a critical component of the therapeutic relationship.").

Physician bias in medical decision making may also have adverse impacts beyond the immediate physician-patient encounter. A perception of physician bias is not only likely to affect a patient's trust in a particular physician, but also may extend to decreased trust in the medical profession and the health care system more generally; especially if patients perceive the bias to be systemic, rather than confined to isolated individual providers.⁵ This distrust of physicians may lead patients to avoid seeking necessary medical care and may also make it more difficult for public health authorities to reach distrustful populations with health-related information. For example, it has been reported that a significant number of Black Americans believe that HIV, the virus that causes AIDS, is part of a genocidal conspiracy to kill African Americans.⁶ This perception may cause at-risk Blacks to refrain from seeking HIV-testing and cause infected Blacks not to pursue treatment options, and thus may contribute directly to Black Americans' higher mortality rates from AIDS.⁷ Thus, the adverse health impact produced by a perception of physician bias may be both broad and profound.

It should, of course, be noted that the negative effects caused by diminished trust (whether particular or general) may flow simply from a perception of physician bias, whether accurate or not. A physician's

5. Cf. Frank M. McClellan, *Is Managed Care Good for What Ails You? Ruminations on Race, Age and Class*, 44 VILL. L. REV. 227, 242-43 (1999) (describing lack of trust of on part of African Americans, particularly the elderly and noting that "in the area of health care delivery, the perceptions of the patient/consumer have tremendous impact on entry into the health care system and critical use of its resources"); see also Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191, 191-92 (1996) (noting African Americans, distrust of health care system and effect of this fear on African Americans' participation in health care system).

6. See Vanessa Northington Gamble, *Under the Shadow of Tuskegee: African Americans and Health Care*, 87 AM. J. PUB. HEALTH 1773, 1775 (1997) (providing evidence that segment of African-American community in United States believes AIDS virus was created to kill African Americans). Data regarding the health care seeking behavior of lesbians provides another example of this effect. See Amy E. Harrison & Vincent M.B. Silenzio, *Comprehensive Care of Lesbian and Gay Patients and Families*, 23 MODELS OF AMBULATORY CARE 31, 36 (1996) (citing L. Zeidenstein, *Gynecological and Childbearing Needs of Lesbians*, 35 J. NURSE MIDWIFERY 10 (1990)). One study shows that nearly half of the lesbians surveyed rarely or never sought gynecologic care, a finding that is particularly striking in light of the fact that many of the women were highly educated (and thus likely were aware of the importance of preventive care and screening) and had business or professional careers (and thus were not likely to be barred from seeking care by financial barriers). See *id.* (noting that "these women had access to health care, yet chose not to use it because of negative experiences with providers").

7. See 1 U.S. COMMISSION ON CIVIL RIGHTS, *THE HEALTH CARE CHALLENGE: ACKNOWLEDGING DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUITY* 27 (1999) [hereinafter *HEALTH CARE CHALLENGE*] (discussing prevalence of AIDS among African Americans in United States); Deborah L. Shelton, *Legacy of Tuskegee: Revelations About the Infamous Syphilis Study Turned Many African Americans Against the U.S. Health Care System*, AM. MED. NEWS, June 3, 1996, at 24.

suboptimal clinical choices, by contrast, result from the operation of actual bias. To assess whether the vignettes launching this Article merely reflect a problem of perception, we must examine the extant evidence regarding how often biased medical decisions occur. If doctors do not in fact make biased medical decisions, then the problem is simply one of perception. Fitting responses therefore should focus on changing an inaccurate perception, not on changing doctor's decisional processes or remedying the adverse affects of biased medical decisions.

Unfortunately, the medical and social sciences literature does not provide a definitive answer to the questions of when and how often physicians' medical decisions are biased. As discussed in Part II, it is surpassingly difficult to design a research protocol to test for the presence of physician bias in medical decisions, while controlling for all potentially confounding variables. Notwithstanding this difficulty, a variety of sources contain persuasive evidence that at least some physicians' decisions are biased some of the time. These sources include peer-reviewed studies in the medical literature evaluating disparities in treatments received by different patient populations, empirical studies of physicians' attitudes and assumptions regarding member characteristics of different patient groups and anecdotal stories. Based on a review of the cumulatively powerful evidence contained in these sources, this Article will proceed on the assumption that the clinical judgment of some physicians is sometimes influenced by patient characteristics unrelated to the patient's need for medical care.⁸ In short, biased medical decisions do occur.

If physician bias does exist and operates in some number of cases, the next question is whether any effective legal response is available to patients who are the subjects of biased medical decisions. This Article undertakes to answer that question. It will examine existing legal frameworks in the areas of both anti-discrimination law and professional liability law to assess whether a patient who has been the victim of a biased medical decision has any avenue to achieve redress.

The topic of physician bias has received some recent attention in the legal literature. In the past several years, law reviews have published a number of articles regarding racial bias in medicine.⁹ These articles re-

8. Because the focus of this Article is whether the law currently provides any avenue for effectively redressing individual instances of biased medical decisions, I need not make the more sweeping claim that physician decisions are systematically biased on any basis. That claim can be found elsewhere, however. See, e.g., René Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79, 81-82 (2001) (asserting that racialized medical research practices lead to racial profiling in health care).

9. See, e.g., M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL'Y L. & ETHICS 95, 95-96 (2001) (noting that since 1999 topic of racial bias in American health care has been targeted as topic for research, discussion and intervention by variety of public and private sector initiatives); Bowser, *supra* note 8, at 80-91 (discussing racial bias in medicine and reviewing medical literature demonstrating that African Americans receive lower quality health care than similarly situated white patients); Barbara A. Noah, *Racial Disparities in the Delivery of*

flect the upwelling of interest outside the legal academy in the mounting evidence regarding the extent and pervasiveness of so-called “health disparities” in the United States between whites and racial and ethnic minorities, particularly African Americans. The catch-all phrase “health disparities” refers to a number of health-related variances between population groups—disparities in health status indicia, in health insurance coverage, in access to health care and in actual treatment received. Evidence of health disparities has captured the attention of the medical community, public health authorities, civil rights activists, the media and policymakers including the U.S. Congress.¹⁰ In March 2002, a panel of the Institute of Medicine issued a comprehensive report examining racial disparities, finding that racial and ethnic minorities in the United States receive lower quality medical care than whites, even when both groups have the same health insurance.¹¹ Racially or ethnically biased medical decisions by individual physicians represent one relatively small piece in the health disparities puzzle, but perhaps it is more amenable to legally oriented discussion than, for example, racial disparities in life expectancy.

The legal literature’s existing examinations of physician bias, however, have each focused on a particular type of bias: racial bias or in several instances, gender bias.¹² They have not attempted an analysis of physician bias as a general problem that extends beyond bias based on race or gender. While this narrow focus may be justified by the distinctive history and nature of racial bias,¹³ or particular issues associated with gender bias, the time is ripe for exploration of physician bias as an inclusive phenomenon. Admitting the existence of a broad range of biased medical decisions may enable an understanding of the likeness of the harms that flow from the operation of physician bias; whether that bias is based on race, gender, disability, sexual orientation, age or other personal characteristics. In ad-

Health Care, 35 SAN DIEGO L. REV. 135, 137 (1998) (discussing “racial bias in the delivery of [health] care”).

10. See Minority Health and Health Disparities Research and Education Act of 2000, Pub. L. No. 106-525, 114 Stat. 2495 (2000) (amending “The Public Health Service Act to improve the health of minority individuals” and recognizing lower quality of health care received by minorities compared to rest of U.S. population).

11. See Sheryl Gay Stolberg, *Race Gap Seen in Health Care of Equally Insured Patients*, N.Y. TIMES, Mar. 21, 2002, at A1 (examining study by Institute of Medicine concluding that racial disparities exist in health care, even when insurance and income are same).

12. See, e.g., Carol Jonann Bess, *Gender Bias in Health Care: A Life or Death Issue for Women with Coronary Heart Disease*, 6 HASTINGS WOMEN’S L.J. 41, 64 (1995) (“Evidence suggests a gender bias exists for women in health care.”); Michelle Oberman & Margie Schaps, *Women’s Health and Managed Care*, 65 TENN. L. REV. 555, 564-69 (1998) (examining gender bias in delivery of health care); Karen H. Rothenberg, *Gender Matters: Implications for Clinical Research and Women’s Health Care*, 32 HOUS. L. REV. 1201, 1204 (1996) (discussing “gender bias in health care”).

13. Cf. Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 AM. J. L. & MED. 203, 210 (2001) (emphasizing that “[a]ny discussion of race, ethnicity, and health care must acknowledge the profound impact of slavery and segregation on American health care.”).

dition, a fuller understanding of physician bias and the sufficiency of existing legal responses to physician bias can provide the necessary foundation for efforts to move forward to develop strategies to decrease the incidence of biased medical decisions and to provide patients harmed by such decisions with some avenue of redress.

Moreover, current efforts within the medical community to develop new approaches to improving the quality of medical care provided,¹⁴ combined with managed care's prompting of a reevaluation of the nature of a physician's professional obligations to his patient,¹⁵ coalesce to make this a particularly opportune time to focus on the problem of physician bias. Because biased medical care is thought of as one form of poor quality medical care,¹⁶ efforts to reduce the incidence of biased medical decisions may be able to piggyback onto efforts to improve medical quality by promoting evidence-based medicine and reducing variability in medical practice.¹⁷ Similarly, physicians' current attentiveness to the question of what duties they owe their patients may provide a "teachable moment" for focusing physicians' attention on eliminating bias as a professional obligation.

This Article will proceed in the following manner: Part II will examine the published evidence that physicians' clinical decisions are biased in some instances. This examination's purpose is not to prove exactly when and why biased decisions occur, but instead to establish that sufficient evidence of bias exists from which we can assume that at least some physicians make biased decisions. Starting with this assumption, the next logical question is whether we should care. In other words, what's wrong with biased medical decisions? Part III will describe briefly two ways in which biased medical decisions are wrong. First, biased medical decisions violate the norms of the professional and personal relationship between physician and patient. Second, they violate social norms of equality of treatment of similarly situated individuals and may help perpetuate unequal distributions of health and related social goods.

If, as asserted, biased medical decisions are somehow wrong, the question becomes whether the law provides a mechanism for responding to

14. See Richard Grol, *Improving the Quality of Medical Care: Building Bridges Among Professional Pride, Payer Profit, and Patient Satisfaction*, 286 JAMA 2578, 2578 (2001) (summarizing recent suggested approaches to improving quality of care).

15. See David Mechanic, *Managed Care and the Imperative for a New Professional Ethic*, 19 HEALTH AFF. 100, 102 (2000) (arguing for re-evaluation and creation of "new professional ethic" for physicians in light of emerging health care changes).

16. See Watson, *supra* note 13, at 203 (asserting that treatment "differences based on race or ethnicity rather than medical need are medical mistakes").

17. See generally COMMITTEE ON QUALITY HEALTH CARE IN AMERICA, *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* (2001) [hereinafter *CROSSING THE QUALITY CHASM*] (advocating for improvements in American health care system including providing health care that is based upon empirical evidence and does not vary based upon personal characteristics of patient, location or socio-economic status (SES)).

this wrong. The remainder of the Article examines whether a patient who is the subject of a biased medical decision has any viable avenue of legal recourse. Part IV considers the possibility of imposing liability on a physician for violating professional duties and Part V examines possible responses based on federal civil rights statutes and barriers to the effectiveness of those responses. The ultimate conclusion is that neither avenue is currently likely to provide many patients complaining of physician bias with any remedy. The Article concludes in Part VI with reflections on how currents of thought in the fields of civil rights enforcement and medical care quality improvement may provide bases for continuing efforts to address the problem of physician bias.

II. SURVEYING THE EVIDENCE OF BIAS IN MEDICAL DECISIONS

A. *Defining the Inquiry*

This Part of the Article examines the evidence, primarily found in the medical literature, that suggests that a physician's choice of medical diagnosis and treatment for an individual patient may, in some cases, be influenced by patient characteristics that are unrelated to the patient's need for medical care. This evidence appears most often in studies identifying disparities in the rates of a particular intervention received by patients according to group-related characteristics such as race or gender. However, any inquiry into the meaning of group-based disparities in the rates of health services must be undertaken with awareness of the recognized pervasiveness of variations in medical practice.

Since the early 1970s health services researchers have demonstrated that the rates of various procedures vary widely by geographic location.¹⁸ These varying practice patterns do not reflect different rates of illness or medical need by geographic region; instead, researchers have attributed them primarily to differences in physician practice styles.¹⁹ In other words, the explanation is not that patients are sick differently in different regions, but that doctors in different regions treat similarly sick patients differently. On reflection, these geographic variations are perhaps not surprising; variations in the rates of services are predictable as long as medical practice is an inexact science. When the appropriate intervention for a patient is not clear, the physician exercises some discretion in making a treatment choice, and either the traits, training, background of the

18. See John Wennberg & Alan Gittelsohn, *Small Area Variations in Health Care Delivery*, 182 *Sci.* 1102, 1102 (1973) (citing empirical studies that find differences in use of health care services that cannot be attributed to differences in illness rates and instead are likely due to differences in physician practice styles). For a current study documenting such variation, see Peter C. Coyte et al., *Physician and Population Determinants of Rates of Middle-Ear Surgery in Ontario*, 286 *JAMA* 2128, 2128 (2001) (finding that "probability of having surgery depends on where one lives").

19. See Alan M. Gittelsohn, *Income, Race, and Surgery in Maryland*, 81 *AM. J. OF PUB. HEALTH* 1435, 1435 (1991) (stating that researchers attribute geographic differences in surgery rates to variations in physician practice styles).

individual physician or characteristics of the medical community can influence those choices.²⁰

Before beginning to examine the possible role of bias in medical treatment decision making, it is critical to isolate the phenomenon targeted for examination. Geographic variations research focuses on the role that geography plays in influencing treatments provided. Other physician-related characteristics, such as physician age, specialty, training and gender may also influence medical decision making and practice styles. For purposes of the present inquiry, the role of these physician-related characteristics must be distinguished from the role of patient-related characteristics in medical decision making. Differentiating between the role of physician-related characteristics and that of patient-related characteristics can be complicated. In some cases, a characteristic of the physician might correlate with a higher likelihood that the physician's medical judgment will be biased by a characteristic of the patient.²¹

Another distinct factor that is largely extrinsic to either the physician's or the patient's makeup may also influence a physician's treatment choices. As public and private health care financing programs have increasingly incorporated managed care methodologies, many physicians practice under reimbursement systems that reward physicians financially for ordering fewer and less expensive interventions. These financial incentives are designed to influence physician practice styles and a robust literature examines the predictable conflict of interest that arises when a patient's best medical interests are contrary to the physician's financial interests.

A final characteristic that may influence a physician's decision whether and how to treat a patient is the patient's own financial ability or inability; this patient attribute, however, lies beyond this Article's focus. Although financial status is a patient characteristic that is not directly related to the patient's need for medical treatment, a decision to refuse to treat a patient who cannot pay for medical services or to limit a patient's treatment options to those for which he has the means to pay is generally

20. As a recent report published by the Institute of Medicine points out: "Variations in approaches today often reflect different local and individual styles of practice and training that may or may not be consistent with the current evidence base." See CROSSING THE QUALITY CHASM, *supra* note 17, at 73 (discussing variations in treatment of similar patients due to physician training location and suggesting that current practices should change so that any differences are due to "differing patient needs and preferences" instead). As will be discussed below, one of the Committee's recommendations is that variation in clinical practice should decrease in order to improve quality. See *infra* Part VI (discussing need for decreased variation in clinical practice); see also Elizabeth A. Mort, *Physician Discretion and Racial Variation in the Use of Surgical Procedures*, 154 ARCHIVES INTERNAL MED. 761, 761-67 (1994).

21. See, e.g., Dana G. Safran et al., *Gender Differences in Medical Treatment: The Case of Physician-Prescribed Activity Restrictions*, 45 SOC. SCI. & MED. 711, 719 (1997) (finding that gender-based attitudinal biases appear to be stronger among male physicians, older physicians and subspecialists).

(though by no means universally) deemed legitimate by both the legal and medical communities.²² Although codes of medical ethics call upon doctors to provide charity care, they do not require a particular doctor to treat every indigent patient who seeks care; nor does the legal system generally impose on doctors the obligation to provide uncompensated care. Differential rates of health insurance coverage undoubtedly play some role in contributing to disparities in levels of care received by different population subgroups.²³ Indeed, some evidence suggests that physicians may harbor a bias against treating “the poor” independent of particular poor patients’ health insurance coverage.²⁴ Nonetheless, while acknowledging the argument that poverty may represent a group-related characteristic that can engender stereotypical attitudes, the difficulty of distinguishing between the acceptable and the unacceptable influences that medical indigency may exert on medical treatment decisions leads me to exclude financial ability and insurance status from the sources of bias on which this Article focuses.

So what is left for examination? This Article’s inquiry will focus on the role that patient characteristics, not related to the patient’s need for medical treatment, play in influencing a physician’s choice of diagnostic or therapeutic intervention. I phrase the question in general terms to emphasize that this is not an article about racist medical decision making per se (or sexist, or ageist, or ablist, or heterosexist or whatever “-ist” medical decision making). Instead, it is a broader examination of how the legal system does or could respond to cases in which a physician’s medical judgment is somehow infected or biased by a non-medical characteristic of the patient.

But even with so cabined an inquiry, assessing when a patient characteristic is indeed unrelated to the patient’s need for medical care may sometimes prove tricky. Group-related characteristics such as race, ethnicity or gender may not generally be related to a patient’s medical needs; indeed, it has been argued that medical research that seeks to attribute particular outcomes to patient race is irrelevant to treatment choices for

22. See Barry R. Furrow, *Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients*, 3 HEALTH MATRIX 31, 34-87 (1993) (addressing legal aspects of obligation to treat the poor); Sidney Dean Watson, *In Search of the Story: Physicians and Charity Care*, 15 ST. LOUIS U. PUB. L. REV. 353, 365 (1996) (exploring failure of bioethical discourse to address physicians’ obligations to treat poor people and suggesting that refusal to treat the poor has become “ethically acceptable conduct”).

23. See Robin M. Weinick et al., *Racial and Ethnic Differences in Access to and Use of Health Care Services, 1977 to 1996*, 57 (Supp. 1) MED. CARE RESEARCH & REV. 36, 50 (2000) (finding that improving equality in income and health insurance coverage would substantially reduce disparities in use of health services but would not eliminate such disparities).

24. See Watson, *supra* note 22, at 364-65 (discussing physician bias against poor).

an individual patient.²⁵ By contrast, a committee of the Institute of Medicine took the stance that demographic characteristics may sometimes be reliable proxies for factors such as patient preferences or anticipated outcomes of care;²⁶ in those instances, such characteristics might appear to be related to the patient's medical needs. Similarly, as psychiatrist Sally Satel asserts, "[when] certain diseases and treatment responses cluster by ethnicity, [r]ecognizing these patterns can help [doctors] diagnose disease more effectively and prescribe medications more effectively."²⁷ Crucial to the question of relatedness to a patient's medical needs is the reliability of the proxy a physician employs in making medical judgments. For example, if clinical research demonstrates that females of reproductive age consistently metabolize a drug at a faster rate than males, then female sex is related to a judgment regarding the drug's proper dosage for a female patient. By contrast, if a physician simply assumes, without scientific support, that females are better able than males to endure pain, the patient's sex should be seen as an unreliable proxy for—and thus not related to—the level of an individual patient's medical need for pain relief.

The high level of uncertainty that still permeates much of medical practice complicates the "relatedness" question. To illustrate, one study examined whether a patient's race influenced the frequency with which nephrologists diagnosed patients with end-stage renal disease as having hypertensive renal disease, as opposed to some other form of underlying kidney disease.²⁸ The researchers' findings suggested that doctors may have been more likely to label African Americans' kidney disease as hypertensive than they were to give white patients a similar diagnosis, even when the patients had similar clinical histories. The researchers concluded that some nephrologists in the study appeared to use race as a diagnostic factor even though the diagnostic validity of that factor is not clear.²⁹ The researchers cautioned that the use of such unvalidated diagnostic criteria

25. See Robert S. Schwartz, *Racial Profiling in Medical Research*, 344 NEW ENG. J. MED. 1392, 1392 (2001) ("[A]ttributing differences in a biologic end point to race is not only imprecise but also of no proven value in treating an individual patient."); see also Bowser, *supra* note 8, at 110 (stating that ascribing differences between patients to race is of no value in treating single patient).

26. See Safran et al., *supra* note 21, at 712 (citing CLINICAL PRACTICE GUIDELINES: DIRECTIONS FOR A NEW PROGRAM (M.J. Field & K.N. Lohr eds., 1990)) (asserting that according to Institute of Medicine Committee, patient's demographic information can "represent reliable proxies" for variables relevant to treatment such as patient preferences and may therefore warrant "differential treatment along these lines").

27. Sally Satel, *I Am a Racially Profiling Doctor*, N.Y. TIMES, May 5, 2002 (Magazine), at 56.

28. See Thomas V. Perneger et al., *Diagnosis of Hypertensive End-Stage Renal Disease: Effect of Patient's Race*, 141 AM. J. OF EPIDEMIOLOGY 10, 10 (1995) (examining study of whether race of patient with end-stage renal disease (ESRD) influences diagnosis of underlying kidney disease made by nephrologists).

29. See *id.* at 13 ("[W]hether or not nephrologists are correct in using the patient's race as grounds for selecting a clinical diagnosis of kidney disease remains uncertain.").

could produce a “self-reinforcing truth.”³⁰ Clinicians employing race as a diagnostic preference may overdiagnose African Americans as having hypertensive renal disease; these diagnoses will be incorporated in epidemiological data regarding disease incidence among racial groups; these data may then be read as supporting the use of race in diagnosing kidney disease because of the high incidence of hypertensive kidney disease among African Americans.³¹ Thus, any assumption that a demographic characteristic is related to a patient’s need for medical treatment should be carefully scrutinized to ascertain its scientific validity.

B. *Evidence Suggesting the Operation of Physician Bias*

1. *Challenges of Research Design and Interpretation*

Having defined the type of physician bias under examination, we move now to inspect research suggesting that these biases sometimes operate in medical treatment decisions. Before describing specific studies, however, a brief examination of the challenges inherent in effectively designing and accurately interpreting studies involving disparities in health care services is in order. First, the temptation to equate a finding of a lower rate of health services received by a particular group with discrimination against that group must be resisted.³² A number of possible explanations—other than discriminatory motive or biased decision making—may explain disparities in utilization. For example, if one demographic group has a higher incidence of a particular condition or tends to be afflicted with a more severe form of the condition, a higher per capita utilization rate for that group (and likewise a lower per capita rate for the less afflicted group) is to be expected.³³

30. *Id.* at 14 (discussing effects of race-specific diagnostic preferences); *see also* Bonnie J. Floyd, *Problems in Accurate Medical Diagnosis of Depression in Female Patients*, 44 SOC. SCI. & MED. 403, 403, 406 (1997) (noting, in context of estimate, that up to 50% of female patients diagnosed as having depressive disorder may be misdiagnosed and that physician’s awareness of publicized gender-related differences in depression rates may increase possibility that female may be (mis)diagnosed as depressed).

31. *See id.* (stating that “[p]hysicians’ beliefs about diagnostic base rates may influence medical judgments”); *cf.* van Ryn & Burke, *supra* note 1, at 822 (suggesting that “epidemiologic evidence is incorporated into physicians’ general belief systems such that population-based likelihoods are applied to individuals even in the presence of disconfirming information”).

32. *See* Noah, *supra* note 9, at 155-56 (citing RANDALL KENNEDY, RACE, CRIME, AND THE LAW 9 (1997)) (stating racial disparities in treatment are not always due to discrimination).

33. *See, e.g.*, Marian E. Gornick, *Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries*, 335 NEW ENG. J. MED. 791, 798 (1996) (noting that higher rate of surgical repair of hip fractures among white women as compared to black women was consistent with higher rates among white women of osteoporosis in neck of femur); *cf.* Kenneth C. Goldberg et al., *Racial and Community Factors Influencing Coronary Artery Bypass Graft Surgery Rates for All 1986 Medicare Patients*, 267 JAMA 1473, 1475 (1992) (raising, but then rejecting, possibility that

In addition, a wide array of factors may play a role in a physician's choice of intervention for a particular patient, and thus may contribute to disparities between groups. Deciding the optimal treatment in any case requires the exercise of complex judgment, taking into account the stage and severity of the patient's condition, any other conditions (or "comorbidities") that affect the patient's baseline health status, the patient's social situation (to the extent it may affect the patient's ability to comply with or benefit from a particular therapy), the patient's values and preferences and whether a patient's insurance will cover a particular therapy. If one group of patients tends to share clinical characteristics rendering a particular treatment medically inadvisable, then that group should have lower utilization rates for the inadvisable procedure.³⁴ The multifactorial nature of medical judgment challenges researchers to control for these factors in an attempt to isolate the role that a group-related, but clinically irrelevant, characteristic plays.³⁵ Thus, the complex nature of medical decision making renders bias in the process difficult to prove conclusively. By the same token, it also renders bias difficult to disprove.³⁶

Isolating the role of and the implications of bias is particularly challenging when the treatment at issue is deemed discretionary, or not clearly in the patient's best medical interests. When a physician must decide between more than one possible intervention, and none of the interventions is conclusively indicated for the patient, factors that are not purely medical may be more likely to sway the physician's choice of intervention.³⁷ In that circumstance, the physician may rely on factors commonly deemed legitimate, such as the patient's preferences, or he may be guided by assumptions about the patient based upon his membership in a particular

higher rates of coronary artery bypass surgery among whites, as compared to blacks, could result from greater need for surgery among white patients).

34. See Chiriboga et al., *A Community-Wide Perspective on Gender Differences and Temporal Trends in the Use of Diagnostic and Revascularization Procedures for Acute Myocardial Infarction*, 71 AM. J. CARDIOLOGY 268, 272 (1993) (noting that some portion of gender-related differences in utilization rates were explained by differing patient and clinical characteristics); Arnold N. Epstein et al., *Racial Disparities in Access to Renal Transplantation: Clinically Appropriate or Due to Underuse or Overuse?*, 343 NEW ENG. J. MED. 1537, 1542 (2000) (reporting results that suggest that lower rates of renal transplantation in part reflected different clinical characteristics among black patients).

35. See Council on Ethical and Judicial Affairs, *Black-White Disparities in Health Care*, 263 JAMA 2344, 2345 (1990) [hereinafter *Black-White Disparities*] (noting difficulty of drawing firm conclusions about race's role in treatment decisions when researchers have not controlled for relevant variables that may account for differences).

36. Cf. Safran et al., *supra* note 21, at 711 ("lack of clarity and precision in our understanding of how medical decisions are made leaves the field open to criticisms of inconsistency, arbitrariness, and bias").

37. Cf. Gittelsohn, *supra* note 19, at 1439 (noting that "the more discretionary the procedure, the lower the relative incidence among Blacks."); Mort, *supra* note 20, at 763-64 (finding lower rates of moderate- and high-discretion procedures among blacks).

group. In addition, the social policy implications of biased medical decision making are less clear when discretionary treatments are involved. If medical science cannot clearly say that “*x* rather than *y* is the preferred treatment for condition *z*,” then it is not at all clear that providing a patient with treatment *y* harms the patient in any concrete sense.³⁸ In other words, we should be most concerned about disparities in the rates of health services provided to specific groups when those disparities can be linked to a difference in health outcomes for members of those groups.³⁹

Thus, the value of research suggesting the operation of bias in medical decision making—at least from a policy perspective—depends on researchers’ ability to link the decisions made to particular health outcomes. Patients are tangibly injured by biased decisions only if a preference for treatment *y* based on race (or gender, etc.) causes patients to suffer worse outcomes than if treatment *x* had been provided.⁴⁰ This point is particularly relevant in combating the common assumption that when it comes to medical care, “more is better.” A higher rate of utilization of a particular procedure by members of one group (e.g., whites), as compared to members of another group (e.g., African Americans), may represent underuse of the procedure by members of the latter group. It may also, however, represent *overuse* of the procedure by members of the former group.⁴¹

38. For example, one recent study found that among elderly men with nonmetastatic prostate cancer, black men were less likely to undergo radical prostatectomy than were white men, but that use of the more conservative radiation therapy did not differ significantly by race. See Klabunde et al., *Trends and Black/White Difference in Treatment for Nonmetastatic Prostate Cancer*, 33 MED. CARE 1337, 1337 (1998) (discussing role of patient preferences in treatment choices for prostate cancer). The authors noted, however, that an expert panel had concluded that for nonmetastatic prostate cancer the two therapies were equivalent in terms of effectiveness and that patient preference should play a large role in treatment choices. See *id.* at 1338 (discussing role of patient preferences in treatment choices for prostate cancer).

39. As two physicians who have been heavily involved in research regarding disparities recently commented, “[u]nless differences in medical care according to race reflect the quality of care and meaningfully affect patients’ survival or quality of life, the existence of racial disparities will remain of far greater interest to social scientists than to policy makers and physicians.” See Arnold M. Epstein & John Z. Ayanian, *Racial Disparities in Medical Care*, 344 NEW ENG. J. MED. 1471, 1472 (2001) (suggesting importance of monitoring racial disparities in health care, especially where differences may affect patient mortality rates or quality of life); see also Mort, *supra* note 20, at 762 (“because the optimal clinical strategy is not known for discretionary procedures, the implications of race-related variation in the rates of discretionary procedures for quality of care are less clear”); cf. Epstein et al., *supra* note 34, at 1537 (describing renal transplantation as an “excellent model” for exploring linkage between disparities and quality of care because good candidates for transplantation can be reliably identified and renal transplantation offers better outcomes to patients than alternative treatment of long-term dialysis).

40. Of course, bias in medical decision making may also produce dignitary injuries even in the absence of physical harms, as will be discussed *infra* in Part IV.C (discussing dignitary injuries).

41. See Gittelsohn, *supra* note 19, at 1435 (“Without efficacy studies, it is not possible to determine whether a high-rate area indicates overuse or a low-rate area

The disparity's appropriate characterization depends on whether the procedure at issue can be shown to improve the health outcomes of those who receive it. If not, the group receiving what some might characterize as a "lower" level of care in fact may have received better quality care because group members have not been subjected to the risks and burdens of the inappropriate therapy.⁴² In other cases, a group's high utilization rates for a procedure may suggest that group members received lower quality care prior to resorting to the procedure. For example, one study suggests that African-American Medicare beneficiaries are more likely than white beneficiaries to undergo an amputation of all or part of a lower limb resulting from complications of diabetes because African Americans are less likely to have their diabetes optimally managed in order to prevent complications.⁴³ Additionally, the women's health movement has questioned the assumption that more medical care is better, particularly with respect to medicine's intervention into women's reproductive functions.⁴⁴

Accordingly, for a study to find meaningful evidence suggestive of physician bias in a disparity in the rates of interventions provided to different patient groups, the researchers must control or adjust for the influence that other variable factors may have on a treatment decision.⁴⁵

underservice."); cf. John A. Ayanian et al., *Racial Differences in the Use of Revascularization Procedures After Coronary Angiography*, 269 JAMA 2642, 2646 (1993) (concluding that whites' greater likelihood of receiving revascularization procedures, as compared to blacks, may reflect overuse in whites or underuse in blacks); Geoffrey P. Sayer & Helena Britt, *Sex Differences in Prescribed Medications: Another Case of Discrimination in General Practice*, 45 SOC. SCI. & MED. 1581, 1586 (1997) (questioning whether different rates of prescriptions written to female patients reflected bias in favor of one sex or bias against other sex). A committee of the Institute of Medicine has described underuse and overuse as two types of poor quality care and has defined them as follows: "Overuse refers to the provision of a health service for which the potential risks outweigh the potential benefits. Underuse indicates that a health care service for which the potential benefits outweigh the potential risks was not provided." See CROSSING THE QUALITY CHASM, *supra* note 17, app. A, at 238 (defining overuse and underuse).

42. See Eric D. Peterson et al., *Racial Variation in the Use of Coronary-Revascularization Procedures: Are the Differences Real? Do They Matter?*, 336 NEW ENG. J. MED. 480, 480 (1997) (noting that differences in utilization rates may reflect receipt of more appropriate care by blacks if differences occurred predominantly in situations in which benefits of intervention were small).

43. See Gornick, *supra* note 33, at 798 (stating that African-American Medicare patients were more likely than whites to suffer amputation due to suboptimal diabetes management); cf. Arvin Fiscella et al., *Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care*, 283 JAMA 2579, 2580 (2000) (noting that "socioeconomic position and race/ethnicity [are] associated with potentially avoidable procedures").

44. See Van Wijk et al., *Gender Perspectives and Quality of Care: Towards Appropriate and Adequate Health Care for Women*, 43 SOC. SCI. & MED. 707, 708 (1996) (challenging assumption that more health care is better health care, especially for women, in light of medicine's interference with women's reproduction).

45. Socioeconomic status is a particularly difficult factor to control or adjust for because minority racial or ethnic status so often overlaps with low socioeconomic status in the United States. See Epstein & Ayanian, *supra* note 39, at 1472

Otherwise, determining whether the disparity flows from bias in the decision making or from other factors is impossible. Furthermore, for the evidence of bias to stimulate any strong remedial effort, the biased decision making should be connected with either actual or probable adverse health outcomes.

Although many published studies demonstrate disparities by race or gender in the rates of particular interventions, relatively few of these studies have met both of the conditions just indicated. The purpose of many of the studies was simply to demonstrate the disparity, not to search for its causes. But even those researchers who have sought to plumb the sources of disparities encounter difficulties in adequately controlling for potentially confounding variables. One cause of this difficulty is the limited demographic information contained in the large administrative databases of patient records that many researchers draw their raw data from. These databases typically contain information provided to third-party payers, such as information obtained by Medicare as part of its claims process. The patient record will include demographic information such as the patient's age, gender, and race and medical information such as the plaintiff's primary diagnosis and all treatments billed for. The record will likely not include information about comorbidities, severity of the condition, patient preferences or social factors affecting treatment choices. As a result, some researchers have urged caution in relying too heavily on the results of research based on these administrative databases.⁴⁶

Despite these difficulties, a number of studies extensively control for these confounding variables and find that a group-related characteristic, unrelated to patients' need for medical treatment, persistently correlates with a disparity in treatment rates. Even the authors of these studies, however, have refrained from concluding that bias based on group membership is the clear or exclusive cause of the disparity.⁴⁷ Instead, their

("Black patients are disproportionately represented in [lower] socioeconomic groups."); Fiscella et al., *supra* note 43, at 2579 (noting that race/ethnicity is "closely intertwined" with socioeconomic status in United States).

46. See David H. Mark, *Race and the Limits of Administrative Data*, 285 JAMA 337, 337 (2001) (cautioning that large databases used in studies "are often extremely limited with respect to assessment of the severity of patients' illness . . . and risk factors for mortality"); Peterson et al., *supra* note 42, at 480 (stating that past research reporting racial differences in cardiac procedures relied upon databases that did not contain clinical information needed to "adjust for differences in severity of disease"); see also Goldberg et al., *supra* note 33, at 1476 (noting reliance on Medicare hospital claims records as limitation in study data).

47. See, e.g., Ayanian et al., *supra* note 41, at 2645 (stating inability to "assess whether differing rates of revascularization procedures represent a racial bias among physicians or whether race is a proxy for other cultural and socioeconomic factors that affect physician or patient behavior"); Epstein et al., *supra* note 34, at 1542 (concluding that reasons underlying racial disparities in rates of renal transplantation are more complex than either underlying clinical differences or race-based barriers to receiving appropriate care); cf. Lewis R. Goldfrank & Robert K. Knopp, *Racially and Ethnically Selective Oligoanalgesia: Is this Racism?*, 35 ANNALS EMERGENCY MED. 79, 79 (2000) (characterizing authors of seventeen studies dem-

conclusions have been more circumspect, suggesting perhaps that the difficult to control for variable of patient preference may be at work, or that the dynamics of the physician-patient interaction need to be examined more closely.⁴⁸ Finally, many of the researchers caution that their findings of disparity based on a group-related characteristic may not be generalizable.⁴⁹ In other words, the appearance that something questionable is going on in the doctor-patient relationship in the 200 or 20,000 cases the researchers studied does not necessarily suggest that similar dynamics pervade medical practice more broadly. To use a medical metaphor, because some number of physicians are infected with group-based biases does not mean that the condition is epidemic or even endemic.

This subpart seeks to highlight some of the complexities in designing and interpreting research studies that address the causes and effects of disparities in health services utilization. This cautionary note is critical to the Article's purpose. If bias does indeed play a role in some medical decisions in a way that may lead to worse patient health outcomes, then the question of whether the legal system provides any effective response becomes quite pressing. By contrast, if studies are not carefully designed or are interpreted in an oversimplified fashion⁵⁰ that *misidentify* physician bias as a primary contributor to harmful disparities in health care utilization rates, then parties rightfully concerned about the disparities may spend their energies barking up the wrong remedial tree and fail to identify or address the true roots of the disparity.⁵¹

Unfortunately, the extant research provides no conclusive answer regarding the role that physician bias plays in producing disparate rates of

onstrating racial disparities as being "exceptionally rigorous in describing [their] results . . . as observations that cannot demonstrate an overt or conscious commitment to racism").

48. See H. Jack Geiger, *Race and Health Care—An American Dilemma?*, 335 NEW ENG. J. MED. 815, 816 (1996) (commenting that as "major confounding variables [are] increasingly controlled and adjusted for, investigators tend to invoke unspecified cultural differences, undocumented patient preferences, or a lack of information about the need for care as reasons for the differences").

49. See, e.g., Perneger et al., *supra* note 28, at 14 (cautioning regarding generalizability of findings); Peterson et al., *supra* note 42, at 485 (stating one of limitations of study is that it may not be generalizable to "national patterns of care"); van Ryn & Burke, *supra* note 1, at 824 (stating findings may not generalize beyond "physicians in New York State treating a sample of post-angiogram [CAD] patients").

50. Cf. Lisa M. Schwartz et al., *Misunderstandings About the Effects of Race and Sex on Physicians' Referrals for Cardiac Catheterization*, 341 NEW ENG. J. MED. 279, 279-81 (1999) (criticizing authors of study regarding physicians' referrals for patients with chest pain for presenting findings in misleading and overstated fashion).

51. Although her critique of political correctness in medicine is broad ranging, at least part of psychiatrist Sally Satel's criticism of "indoctrinologists" is directed at what she perceives to be the misdirection of energy that flows from a focus on alleged racial and gender inequalities in health care. See SALLY SATEL, PC, M.D., *HOW POLITICAL CORRECTNESS IS CORRUPTING MEDICINE* 155-192 (2000) (discussing racial inequalities in physician-patient relationship).

health services consumption. Nonetheless, the studies described in the following sections, taken together, strongly suggest that physician bias, whether conscious or subconscious, infects some number of medical decisions and are thus sufficient to compel a serious inquiry into possible legal responses.

2. *Evidence of Bias Based on Race*

Our review of the evidence suggesting physician bias begins with research into racial disparities because researchers' efforts have concentrated in this area. Over the past fifteen years, a burgeoning number of published articles have examined racial disparities in the receipt of health services.⁵² Many of these articles have sought simply to identify the existence and magnitude of disparities between racial groups and have not sought to isolate the causes of the disparities. As such, these articles do not suggest physician bias as the particular source of disparity over other potential sources.⁵³ A number of studies, however, have attempted to control or adjust for as many clinical and nonclinical variables as possible in order to determine whether racial disparities persist.⁵⁴ Although the results of recent studies are not entirely consistent,⁵⁵ several of these studies do find that race continues as a determinative factor regarding the receipt

52. See generally *Black-White Disparities*, *supra* note 35, at 2344-46 (discussing racial disparities in health care between black and white populations). The amount of research devoted to disparities between majority and minority ethnic (as opposed to racial) groups has been far less, but is growing. See Fiscella et al., *supra* note 43, at 2579-80 (reviewing differences in health care between different racial, ethnic and socioeconomic groups).

53. See, e.g., Gornick, *supra* note 33, at 797-98 (suggesting list of possible reasons for disparity); Charles Maynard et al., *Blacks in the Coronary Artery Surgery Study (CASS): Race and Clinical Decision Making*, 76 AM. J. PUB. HEALTH 1446, 1447 (1986) (documenting disparity in bypass surgery rates without addressing causes).

54. See, e.g., Ayanian et al., *supra* note 41, at 2644-45 (finding that, even after controlling for age, sex, region, Medicaid eligibility, principal diagnosis, comorbid diagnoses and hospital characteristics, white Medicare beneficiaries were significantly more likely than black beneficiaries to undergo revascularization procedure after coronary angiography); Elizabeth H. Naumburg et al., *Racial Differentials in the Identification of Hypercholesterolemia*, 36 J. FAM. PRAC. 425, 425-30 (1993) (finding that, even after controlling for age, sex, insurance status, socioeconomic status, number of visits and other cardiovascular risk factors, black patients were less likely than white patients to be screened for cholesterol levels, and even when screened, were less frequently diagnosed with hypercholesterolemia than white patients with comparable cholesterol levels).

55. For example, one recent study that compared racial differences in mortality rates among men admitted to the hospitals in the Veterans Administration system, which is government funded and poses few financial barriers, found that thirty day mortality rates for black patients were lower than those for white patients in six different categories of medical diagnosis. See Ashish K. Jha et al., *Racial Differences in Mortality Among Men Hospitalized in the Veterans Affairs Health Care System*, 285 JAMA 297, 299 (2001) (finding lower thirty-day mortality rates for black patients compared to white patients for diagnoses of angina, pneumonia, congestive heart failure, chronic obstructive pulmonary disease, diabetes and chronic renal failure).

of health services even when adjustments are made for potentially confounding variables. This subsection will describe a handful⁵⁶ of these recent studies strongly suggesting that some dynamic in the patient-physician interaction—possibly including physician bias—plays a significant role in contributing to disparities.⁵⁷

The point of this description bears emphasis. The goal is not to try and prove that medical decisions by doctors in all contexts are racially biased; that ambitious effort—if relying on existing evidence—would be doomed to failure. Instead, the description's more modest purpose is to provide a sufficient evidentiary basis for concluding that race apparently does play a role in influencing physicians' medical treatment decisions in at least some cases. That assertion, if accepted, justifies an examination of potential legal responses.

a. Disparities in Drug Therapies for HIV

In a study published in 1994, researchers from Johns Hopkins examined whether racial differences in prescribed drug use at the time of patients' presentation at an urban HIV clinic could be attributed to differences in demographic factors other than race.⁵⁸ Specifically, the authors of the study analyzed whether patients—all of whom had been diagnosed with HIV—had been prescribed either antiretroviral therapy or prophylactic therapy for *Pneumocystis carinii* pneumonia (PCP), before coming to the clinic. The authors noted that the optimal use of these prescription drug therapies is clearly defined in clinical guidelines issued by public health agencies;⁵⁹ thus, the drugs should not be seen as discretionary therapies.

The results of the authors' analysis showed that black patients were significantly less likely to have been prescribed either antiretroviral therapy or PCP prophylaxis prior to their presentation at the clinic.⁶⁰ Upon

56. This Article does not seek to provide a comprehensive review of the voluminous literature regarding racial disparities in health services. For such a review, see ROBERT M. MAYBERRY ET AL., *RACIAL AND ETHNIC DIFFERENCES IN ACCESS TO MEDICAL CARE: A SYNTHESIS OF THE LITERATURE* (1999).

57. See Geiger, *supra* note 48, at 816

(With major confounding variables increasingly controlled and adjusted for, investigators tend to invoke unspecified cultural differences, undocumented patient preferences, or a lack of information about the need for care as reasons for the differences. The alternative explanation is racism—that is, racially discriminatory rationing by physicians and health care institutions.)

58. Richard D. Moore et al., *Racial Differences in the Use of Drug Therapy for HIV Disease in an Urban Community*, 330 *NEW ENG. J. MED.* 763, 763 (1994) (examining whether differences in treatment of HIV patients could be attributed to factors other than race).

59. See *id.* (citing to guidelines issued by National Institute of Allergy and Infectious Diseases and by Public Health Service).

60. The results were that 63% of eligible whites, but only 48% of eligible blacks had received antiretroviral therapy, and that 82% of eligible whites, but only 58% of eligible blacks had received PCP prophylaxis. See *id.* at 764 (showing Afri-

further analysis of the data, the authors concluded that neither data on the patients' insurance coverage and income, nor such behavior as injection-drug use, nor demographic (sex and age) or socioeconomic (level of education and place of residence) factors explained the racial disparities. The analysis did show that black patients were less likely than whites to have had a usual source of medical care through which they could have received appropriate drug therapy before being referred to the clinic. But, the data also indicated that even among patients who identified a usual source of care, whites were more likely than blacks to receive drug therapy. The authors suggested that the disparities might flow from barriers to the spread of medical information that affect blacks more than whites, misconceptions about HIV and AIDS that are more common among blacks and a distrust of health authorities in the black community. The authors, however, also identified a final potential barrier to appropriate care for blacks: physicians' prescribing habits. After citing to studies suggesting that race may influence a physician's treatment recommendations, the authors emphasized that no evidence-based reasons existed for racial disparities in prescribing drug therapies for persons infected with HIV.⁶¹ In other words, if race influenced physicians' likelihood of prescribing either antiretroviral therapy or PCP prophylaxis for patients in the study, it was not because race was medically relevant to the patients' need for the therapy.

b. Disparities in Coronary Revascularization Procedures

In a study published in 1997, a group of researchers from Duke University undertook to advance an already large body of research reporting racial disparities in the use of cardiac procedures. They examined whether clinical features of patients' heart disease could explain racial differences in the use of two cardiac procedures by patients following cardiac catheterization.⁶² The researchers analyzed the medical records of patients who had been diagnosed with cardiac disease after a cardiac catheterization, both to discover whether coronary angioplasty or bypass surgery had been used and to determine whether the patient's age, sex, insurance status or a variety of clinical factors were significant predictors of which therapy would be chosen. The analysis revealed that the severity of the patient's disease had the strongest influence on which treatment was used, with the more severe disease being more likely to be treated with bypass surgery rather than angioplasty. After adjusting the rates of usage for all

can Americans received antiretroviral therapy and PCP prophylaxis at lower rates than whites before presentation to clinic).

61. *See id.* at 766-67 (discussing racial disparities found, even after controlling for possible variables, despite fact that race is not medically relevant to type of treatment prescribed).

62. *See* Peterson et al., *supra* note 42, at 480-81 (exploring whether racial differences exist in use of coronary angioplasty and bypass surgery and whether differences could be explained by clinical features of patients).

of the clinical and nonclinical variables employed,⁶³ the researchers found that while blacks were only marginally less likely than whites to receive angioplasty, blacks were thirty-two percent less likely to undergo bypass surgery. Moreover, the racial disparity in the utilization of bypass surgery was more marked among patients with more severe disease. Finally, by conducting follow up with the patients studied, the researchers found that black patients were eighteen percent more likely to die in the five-year period following their catheterization, even after adjustment for baseline prognostic factors.⁶⁴ Given this linkage to unfavorable outcomes, the researchers concluded that revascularization procedures may have been underused in treating black patients.⁶⁵

In discussing their finding that race significantly affected both the chances of receiving bypass surgery and health outcomes, the authors characterized their results as “disturbing” because they were not attributable to differences in clinical characteristics. Discussing the few remaining explanations for the racial disparity, the authors raised the possibility that the patient’s or the physician’s preference for one cardiac intervention over another might vary according to race and concluded that “physician-patient interactions become key to understanding practice patterns.”⁶⁶ Thus, a study that links racial differences in utilization to less favorable health outcomes for black patients and that eliminates a variety of clinical and demographic factors as possible explanations, strongly suggests that some part of the dynamic that occurs between physician and patient acts to the disadvantage of some black patients.

c. Disparities in the Treatment of Lung Cancer

Another study also identified a clear linkage between a lower rate of surgical interventions and worse outcomes for African-American patients. Researchers engaged in a population-based study of ten thousand patients who had been diagnosed with early-stage, non-small-cell lung cancer to estimate the differences in the rates of surgical treatment of those patients.⁶⁷ For patients whose lung cancer is diagnosed early, surgical resec-

63. The researchers took into account insurance status, age, sex, several different comorbid health conditions, smoking status, the duration of the patient’s angina, unstable angina, score on the Coronary Artery Disease Index, ejection fraction, type of admitting service and the year of the procedure. *See id.* at 482.

64. *See id.* at 482-84 (demonstrating that racial disparities increased with severity of disease and higher mortality rate among African Americans five years after surgery).

65. *See id.* at 485 (“[R]evascularization procedures may have been underused in treating blacks.”).

66. *Id.* at 484 (raising possibility that patient or physician preferences or interactions may explain racial disparities).

67. Peter B. Bach et al., *Racial Differences in the Treatment of Early-Stage Lung Cancer*, 341 *NEW ENGL. J. MED.* 1198, 1198 (1999) (examining whether difference in rates of surgical treatment explain different survival rates of these two populations).

tion offers a substantial cure rate; by contrast, patients who fail to receive the intervention have a median survival of less than one year. Thus, surgical resection is clearly the optimal treatment for early-stage non-small-cell lung cancer. The study's findings revealed, however, that black patients were less likely (by 12.7 percentage points) than white patients to undergo surgical resection, even when the researchers controlled for age, sex, stage of disease, type of insurance coverage, availability of care, income and co-existing illness.⁶⁸ Further, the researchers estimated that the difference in surgery rates resulted in significantly lower survival rates for black patients.⁶⁹

In discussing their research results, the authors distinguished this study from others that demonstrated variations in practice patterns. Unlike the therapies considered in many other studies, surgical resection of early-stage non-small-cell lung cancer is not discretionary—instead it is unambiguously the optimal therapy. The researchers disclaimed any ability to explain why blacks received lower rates of resection, but identified as possible explanations racial differences in patient preferences or physicians' failure to offer black patients the optimal treatment as frequently as it is offered to whites.⁷⁰ Again, while this study does not prove that physician bias accounted for the differential rate of surgeries for black patients, by disproving the role of a number of other clinical and nonclinical factors, it leaves physician bias as one of the few remaining possible explanations.

d. Disparities in Pain Relief Practices

A study published in 2000 describes how African-American patients in a hospital's emergency department (ED) were less likely than white patients to receive medications for pain relief.⁷¹ The researchers conducted

68. *See id.* at 1201-02 (finding that, even controlling for possible confounding variables, blacks received surgical resection less often and had lower survival rates).

69. To estimate the impact of the differential on outcomes, the researchers diagrammed the outcomes of a hypothetical cohort of 1000 white patients and 1000 black patients who underwent surgical resection at the rates found by the study and who demonstrated the survival rates (for both those who did and those who did not undergo surgery) found by the study. *See id.* at 1203. Of the cohort, 341 white patients survived for 5 years, but only 264 black patients did. A slightly (but non-significantly) lower survival rate for blacks following surgery contributed to the overall difference in survival, but the researchers found that the majority of the survival differential was the result of "the failure to provide surgical treatment for a curable disease." *See id.* at 1200-01 (attributing that lower overall survival rate for blacks *was* statistically significant, but by contrast, among patients of both races *who received the surgery*, blacks had statistically insignificant lower rate of survival than whites).

70. *See id.* at 1204 (discussing possible explanations for racial disparities found).

71. *See* Knox H. Todd et al., *Ethnicity and Analgesic Practice*, 35 ANNALS OF EMERGENCY MED. 11, 11 (2000) (describing study indicating that white patients were significantly more likely than black patients to receive ED analgesics despite similar pain complaints).

a record review for all black and white patients that presented with isolated long-bone fractures at the urban hospital's ED over a forty-month time period. They used a multiple logistic regression to establish race's independent effect on analgesic use, while controlling for variables including time since injury, time in the ED, shift of presentation, need for fracture reduction and payer status. After controlling for these variables, the researchers found that black patients were more likely than whites to receive no analgesia for pain relief in the ED.⁷²

In discussing their results, which were similar to those produced by an earlier study comparing the rates of analgesic administration to white and Hispanic patients,⁷³ the authors discounted the possibility that the differences in pain medication ordered could have resulted either from racial differences in the pain experienced by patients or from racial differences in the assessment of the pain by health professionals. Instead, the researchers indicated that their findings suggested that patient race affected physicians' decisions to administer analgesics independently of any clinical criteria.⁷⁴ In two editorials accompanying the study, emergency physicians noted the existence of potentially confounding covariables that the study had not controlled for. The editorialists, nonetheless, emphasized the need not only to conduct further studies on the existence and causes of racial and ethnic disparities in pain management, but to confront and respond to the real possibility that physician bias contributes to the disparities,⁷⁵ particularly in light of other studies with similar results.⁷⁶

e. Disparities in Treatment for Stroke

Most recently, researchers have reported that black patients who have suffered a stroke are significantly less likely than white patients to receive

72. See *id.* at 13-14 (showing that 57% of black patients versus 74% of white patients received analgesics for extremity fractures, indicating 66% greater risk for black patients).

73. See Knox H. Todd et al., *Ethnicity as a Risk Factor for Inadequate Emergency Department Analgesia*, 269 JAMA 1537, 1538 (1993) (finding that Hispanic patients with extremity fractures were less likely to receive analgesia than similar non-Hispanic whites).

74. See Todd et al., *supra* note 71, at 14-15 (suggesting that race of patient may affect physician's decision to administer analgesics).

75. See Marcus L. Martin, *Ethnicity and Analgesic Practice: An Editorial*, 35 ANALS EMERGENCY MED. 77, 78 (2000); Goldfrank & Knopp, *supra* note 47, at 79 (discussing studies demonstrating that African Americans and Hispanics are more likely to receive "insufficient and inappropriate analgesia," and less likely to receive "appropriate analgesic care").

76. For a summary and discussion of the literature regarding racial and ethnic disparities in pain treatment, see Vence L. Bonham, *Race, Ethnicity, and Pain Treatment: Striving to Understand the Causes and Solutions to the Disparities in Pain Treatment*, 29 J. L. MED. & ETHICS 52, 53-61 (2001) (reviewing medical literature on racial disparities in pain treatment); see also Neil D. Rosenberg, *2 Levels of Treatment: Pain Control Lags for Minorities and Women*, MILWAUKEE J. SENTINEL, April 22, 2001, at 1G (providing anecdotal evidence of inadequate pain control for black patients with sickle cell anemia).

tissue-type plasminogen activator (tPA) (an effective therapy for ischemic stroke if it is initiated within three hours of the onset of stroke symptoms).⁷⁷ Although tPA is a relatively new therapy, published consensus guidelines recommend its use,⁷⁸ and the authors of the study describe it as the “first proven therapy for acute ischemic stroke.”⁷⁹ The researchers examined the medical records of patients admitted for ischemic stroke at forty-two academic medical centers, comparing the rates of tPA use for white patients and African-American patients. When the researchers limited their analysis to patients who were candidates for tPA (i.e., those patients who had arrived at the hospital within three hours of symptom onset and who did not have any other contraindication to tPA use), they found that black tPA candidates were only about one third as likely to receive tPA as white candidates, even after adjusting for age, gender, insurance status and stroke severity.⁸⁰

After noting that the magnitude of the disparity found in the study was quite large in comparison to documented racial disparities for other procedures, the researchers considered possible explanations. They indicated that neither the failure of blacks to seek medical care quickly nor ethnic differences in stroke etiology or severity appeared to explain the disparity in tPA usage. They considered the possibility that blacks’ greater distrust of the medical system and lack of confidence in treatment recommendations could contribute to the disparity, but noted that no black patients in the study had been documented as declining offered tPA treatment.⁸¹ Finally, the researchers considered the possibility that biases based on ethnicity and socioeconomic status explained the disparities. While calling for more detailed analyses of factors leading to treatment and acknowledging their inability to definitively identify racism as the primary cause of the disparity, the researchers concluded that racism likely contributed to the disparity in tPA treatment for ischemic stroke and called on practitioners to “carefully examine their own motivations when withholding this proven therapy.”⁸²

77. See S. Claiborne Johnston et al., *Utilization of Intravenous Tissue-Type Plasminogen Activator for Ischemic Stroke at Academic Medical Centers: The Influence of Ethnicity*, 32 *STROKE* 1061, 1064 (2001) (citing tPA candidates with ischemic strokes).

78. See *id.* at 1061 (citing to guidelines issued by American Academy of Neurology and by Special Writing Group of Stroke Council of American Heart Association).

79. *Id.* at 1066.

80. See *id.* at 1063.

81. By contrast, three white patients offered tPA treatment declined it. See *id.* at 1065.

82. *Id.* at 1065-66.

3. *How Might Race Play a Role in Treatment Decisions?*

Taken together, the foregoing studies—along with other studies documenting racial disparities in the use of therapeutic interventions⁸³—suggest that doctors, as a group, may be less likely to provide black patients than white patients with aggressive therapies for life-threatening conditions,⁸⁴ effective preventive care⁸⁵ and effective pain relief. These differences cannot be explained away by clinical or nonclinical factors independent of the patient's race. Thus, we are left to confront the inevitable conclusion that a patient's race may play some role in a physician's decision of what therapeutic intervention to provide.⁸⁶

I hasten to interject that by asserting that race plays some role in medical decision making, I am not asserting that physicians in the U.S. are bigoted or malevolent racists who believe that African-American patients should receive a lower level of care than whites. While it is certainly plausible that cases of conscious, deliberate decisions to treat blacks less favorably than whites occur in medical practice (as they do in other settings), it seems far more likely that a patient's race influences treatment decisions in a more subtle, less overt fashion. One possible explanation is that physicians may unconsciously employ race-based assumptions or stereotypes in making judgments regarding therapeutic options.

The subject of how physicians make decisions and the possible operation of stereotypes has been examined far less often than the existence of racial disparities in utilization rates. Some evidence, however, exists that begins to suggest how patient race may affect physicians' perceptions

83. I hasten to emphasize again that the articles described in the text represent only a small fraction of the volume of literature documenting racial disparities. See generally Robert M. Mayberry et al., *Racial and Ethnic Differences in Access to Medical Care*, 57 MED. CARE RES. & REV. 108 (Supp. 1 2000) (discussing wealth of literature concerning disparities in health services between whites and racial and ethnic minorities). I chose to describe these studies because by their design and results they were, to my mind, the best evidence that physician bias plays some role in producing the disparities.

84. See, e.g., Johnston et al., *supra* note 77, at 1065 (stating that disparities have tended to be greater for newer and more aggressive therapies and for therapies involving greater physician or patient discretion).

85. See Naumburg et al., *supra* note 54, 425-30 (finding lower likelihood that black patients will be screened for cholesterol levels).

86. By characterizing this conclusion as "inevitable," I do not ignore the patient's role in the physician-patient interaction. I recognize that patient preferences may vary by racial or cultural group and that blacks' distrust of the medical system, discussed more fully *infra* notes 93-98 and accompanying text, may lead some black patients to be less aggressive in seeking and less compliant in accepting medical interventions. That said, I find it incredible that racial differences in patient preferences account fully for the documented disparities, and I am thus convinced that race influences physicians' decisions in some residual number of cases. *But cf.* Jersey Chen et al., *Racial Differences in the Use of Cardiac Catheterization After Acute Myocardial Infarction*, 344 NEW ENG. J. MED. 1443, 1445 (2001) (reporting that racial differences in care among study participants did not vary depending on whether patient's physician was white or black).

about patients. For example, one recent study examines how patient race and socioeconomic status affect physician beliefs about patient personal and psychosocial traits, patient behavior and patient role demands.⁸⁷ The researchers used survey data to examine these effects during encounters between physicians and patients following an angiogram. After controlling for a number of physician characteristics and patient characteristics such as patient age, sex, frailty and social assertiveness, the researchers found that the survey results indicated that physicians tended to perceive black and lower socioeconomic patients more negatively on a number of levels. With respect to race, physicians were more likely to view black patients as being at risk for substance abuse and for noncompliance with cardiac rehabilitation and as having inadequate social support. Physicians were also less likely to report feelings of personal affiliation with black patients and judged black patients to be less intelligent than white patients, even when patient age, sex, income and education were controlled for.⁸⁸

In discussing their results, the researchers considered the possibility that physicians' perceptions were simply accurate observations of individual patient differences that, when aggregated, resulted in group differences. They rejected this possibility as a complete explanation because physicians rated black patients as less educated than white patients, when in fact the two groups were similarly educated.⁸⁹ The alternative explanation offered by the researchers was that physicians incorporated epidemiologic evidence regarding population-based likelihoods into their general belief systems. Even though patient-specific information disconfirmed the

87. See van Ryn & Burke, *supra* note 1, at 820-21 (discussing how race and SES affect physicians' perceptions of patients); see also Glyn Lewis et al., *Are British Psychiatrists Racist?*, 157 BRIT. J. PSYCHIATRY 410, 410 (1990) (finding that questionnaire results reflected stereotype of black person presenting with psychosis and supported view that "race-thinking" is common among British psychiatrists).

88. See van Ryn & Burke, *supra* note 1, at 821 (suggesting physicians' perceptions are negatively influenced by patients' race and SES). With respect to low socioeconomic status, physicians in the study generally gave patients with a low socioeconomic status more negative ratings on personality characteristics and level of intelligence. In addition, these patients were judged as less likely to be treatment compliant, less likely to have significant career demands and more likely to have inadequate social support. See *id.* Although the researchers separated out these findings, they also emphasized the importance of potential interactions:

[I]t is important to note that although race and SES each have independent and individual effects on physicians' perceptions, considering them separately may result in an underestimation of the effect of socio-demographic characteristics on physician perceptions and quality of care. Race is highly correlated with SES, . . . thus, physicians' negative attributions and those towards Blacks and those of lower SES may have a powerful cumulative effect in the clinical setting.

Id.

89. See *id.* at 822-23 (suggesting that physicians' attributions could reflect true population differences, but then partially rejecting this theory based upon evidence that physicians rated African Americans as less educated than Whites even when actual educational levels were taken into account).

likelihoods, the physicians applied them to individual patients. In this fashion, epidemiologic information could effectively function as stereotypes and bias the way that physicians processed information about individual patients.⁹⁰ The authors identified these differences in perceptions and feelings of affiliation as possible explanations for the racial treatment disparities documented in the medical literature.⁹¹

A number of commentators have also suggested that physicians may unconsciously employ racial stereotypes or race-based assumptions in clinical decision making and thereby contribute to racial disparities in receipt of health services. Marian Gornick, who has extensively studied disparities among Medicare beneficiaries, describes how physician perceptions may operate to influence treatment choices:

[T]he course of treatment physicians . . . recommend to their patients may be influenced by stereotypical beliefs about the behavior of their patients. Physicians . . . may believe that poor and minority patients are more likely to break appointments and to misunderstand complex information, and less likely to adhere to their orders. These perceptions may affect—perhaps subconsciously—the decision-making process and lead physicians to refrain from orders that require patient compliance and to hesitate before recommending certain procedures if they assume the pa-

90. *See id.* (explaining that physicians may internalize population-based probabilities, applying them even in face of disconfirming information about individual patients). Of course, a third alternative possibility is that physicians may also have incorporated popular, non-evidence-based assumptions about group characteristics (and not purely epidemiologic information) into their general belief systems and applied them to individual patients. *See* Saif, S. Rathore et al., *The Effects of Patient Sex and Race on Medical Students' Ratings of Quality of Life*, 108 AM. J. MED. 561, 564 (2000) (stating biases exist even early in medical training before students are fully acculturated, therefore lacking clinical experience that would have influenced their attributions). In another study, researchers sought to test whether a patient's race or sex affected medical students' assessments of the way the patient valued a particular state of health. *See id.* (examining whether patients' or physicians' race or sex changed physician ratings of patients' health state). The researchers found that students perceived a black woman as having a less desirable health state than a white man with identical symptoms. *See id.* (finding medical students rated African-American female's health state lower than white males with identical case presentation). Because the medical students studied had not yet experienced any clinical training, the researchers reasoned that the differences may have derived from ideas predating their medical education and reflected race and sex bias in the general population. *See id.* (concluding that because biases in medical students' ratings of health state existed prior to starting their clinical training, they may reflect biases existing in general population, but still may unconsciously effect clinical decisions).

91. *But cf.* Satel, *supra* note 51, at 162 (pointing out that one study examining how physicians made referrals of patients for cardiac catheterization found that study physicians' perceptions of black patient-actors were more positive than their perceptions of white patient-actors).

tient does not live in an environment that is conducive to the aftercare needed for the best outcomes of the procedure⁹²

Other commentators have described the operation of racial bias as “subtle”⁹³ or “nuanced” and not perceived by the physician.⁹⁴

Although patients’ preferences for therapies that are less aggressive, less expensive or more “tried and true” is always a potential (though extremely difficult to document) explanation of treatment disparities, a particular aspect of the oft-cited preference of black patients for less aggressive or less risky therapies bears noting at this point. It is conventional wisdom now that African Americans, as a group, have a higher than average level of distrust towards doctors.⁹⁵ This distrust is typically traced to a history of racist medical practices in the United States. Although the history of segregated and racially discriminatory medical research and treatment practices both pre- and post-dates it,⁹⁶ the Tuskegee Syphilis Study—in which the U.S. Public Health Service sponsored research over four decades that examined the progression of untreated syphilis in poor black men in Alabama—is often cited as the paradigmatic example of racist medicine.⁹⁷ Although many aspects of the study are disturbing, two of the most egregiously unethical facts are that the researchers never obtained any kind of informed consent from the black men infected with

92. *supra* note 1, at 43. Gornick makes this point after having earlier rejected the idea that racial and minority discrimination is the primary explanation for disparities. *See id.* at 39 (suggesting that racial and minority discrimination cannot completely account for differences between African Americans and Whites in use of health care services). Thus, she appears to distinguish intentional and knowing discrimination from unwitting reliance on stereotypes. *See id.* (differentiating between physicians’ stereotypical beliefs about group which may be held consciously and decisions these perceptions may affect unconsciously).

93. *See* Geiger, *supra* note 48, at 816 (“[I]f racism is involved it is unlikely to be overt or even conscious Are [clinical criteria] applied equitably, or are they subtly influenced by racial stereotyping on the part of time-pressured physicians, reinforced both by institutional attitudes and by unwarranted assumptions about prevalences and outcomes?”); *see also* Harold P. Freeman & Richard Payne, *Racial Injustice in Health Care*, 342 *NEW ENG. J. MED.* 1045, 1046 (2000) (describing “common thread” in studies finding disparities as “a subtle form of racial bias on the part of medical care providers . . . even though predominantly unintentional”).

94. *See* Epstein & Ayanian, *supra* note 39, at 1472 (“Physicians may have various biases, but they often do not perceive them and would not report them as such. Thus, it is no surprise that previous studies have not directly documented bias.”).

95. *See generally* Randall, *supra* note 5, at 196 (finding that causation of African Americans’ fear and distrust of health care system is due to history of experimentation and abuse).

96. For a comprehensive history of medical care for African Americans until 1900, *see generally* W. MICHAEL BYRD & LINDA A. CLAYTON, *AN AMERICAN HEALTH DILEMMA: A MEDICAL HISTORY OF AFRICAN AMERICANS AND THE PROBLEM OF RACE: BEGINNINGS TO 1900* (2000) (addressing issues surrounding race and racism relative to health care in America).

97. *See* Gamble, *supra* note 6, at 1773 (suggesting Tuskegee study to be major reason behind African American distrust of health institutions).

syphilis to be part of the research, and as effective treatments for syphilis were developed, the researchers deprived participants of those treatments.

In light of the history of institutionalized racism in American medicine and the Tuskegee study in particular, it is hardly surprising that black Americans may be wary of treatment recommendations made by doctors and suspect that the health care establishment is pursuing goals other than the black patient's best interests. Indeed, some studies indicate that blacks may be less likely than whites to consent to some aggressive therapies. Based on this evidence and perhaps their own practice experience, "clinicians may believe that whites are more likely than blacks to prefer intensive medical treatment or surgical therapy"⁹⁸ and consequently may be less likely to offer black patients aggressive therapy. Thus, the history of racial abuses in American medicine may have had the effect of putting into motion a vicious cycle: The history of discrimination causes blacks, as a group, to distrust white doctors; because blacks distrust doctors, they are generally more likely to decline aggressive or risky medical treatment; since blacks as a group are more likely to decline aggressive treatments, doctors (employing stereotypes) assume that individual black patients will prefer less aggressive treatment; and because doctors make this assumption, they are less likely to offer aggressive treatment to their black patients.⁹⁹

This scenario, if accurate, raises thorny questions about the appropriate response by medical practitioners. Does a physician treating black patients satisfy her ethical and legal obligations simply by making sure that she makes decisions for each patient solely on the basis of that patient's individual needs and that patient's medical information, without employing assumptions or stereotypes? If so, that physician's treatment recommendations will be unbiased, but resulting treatment patterns may still reflect some residual racial disparity because of the greater tendency of blacks, as a group, to decline aggressive treatments. The residual disparity could be characterized as reflecting patient preferences, a characterization that would allow the disparity (and any resulting adverse health outcomes) to be deemed acceptable out of respect for patient autonomy, and not the product of inequitable or biased medical judgments.¹⁰⁰ Surely this com-

98. Epstein & Ayanian, *supra* note 39, at 1471.

99. One of the authors of the study regarding differentials in stroke treatment discussed *supra* in Part IIB2e, suggested such an explanation for the disparities found in that study. In an interview, S. Claiborne Johnston noted that other studies had shown that blacks are more likely to reject risky medical treatment and stated "I think doctors internalize that. Because of that, they may not be offering the drug to African Americans as frequently, thinking that they may not accept the risk." *Race Bias in Stroke Treatment Found*, LAS VEGAS SUN, May 4, 2001; see also Bowser, *supra* note 8, at 96 (suggesting that race-based profiling exists in health care arena and significantly influences medical providers' clinical judgment).

100. For a discussion of how increasing respect for patient preferences in treatment decision making may actually reinforce racial disparities, see Jeffrey N. Katz, *Patient Preferences and Health Disparities*, 286 JAMA 1506, 1506-09 (2001).

placent conclusion cannot end the analysis, for the patients' preferences themselves are the product of African Americans' experiences of racist medicine. Thus, the question would become whether medicine needs to go beyond cleansing clinical decision making of all hints of bias, and additionally whether it needs to take affirmative steps to re-assure black patients of physicians' trustworthiness in an attempt to mold the patients' preferences.¹⁰¹ While possible legal remedies for biased decisions will be discussed below, this question of American medicine's moral obligation to make amends for past discrimination ties intimately into an assessment of how race plays a role in physicians' medical treatment choices.

4. *Evidence of Bias based on Gender*

When our attention shifts to sex-based differences in health services utilization, the evidence of disparities is less voluminous and the challenge of isolating bias as a cause of the disparities is more challenging. Some research into the existence of sex-based disparities in utilization has found either that no disparity exists¹⁰² or that the disparity exists only in limited areas.¹⁰³ Moreover, other research suggests that sex-related disparities in treatment may sometimes reflect more appropriate care for women than men.¹⁰⁴ Nonetheless, the cumulative evidence of disparities raises serious concerns that gender bias sometimes may lead to potentially harmful treatment differentials, in the form of either more or less frequent interventions for women.

One difficulty in assessing the meaning of sex-based disparities lies in determining when disparities in health care usage reflect sex-based differ-

101. As in other contexts, the undertaking of "affirmative action" (here to convince black patients that doctors seek to advance the patients' best interests) would be justified to remedy the lingering effects of past discrimination. *See, e.g.*, Goldfrank & Knopp, *supra* note 47, at 80-81 (suggesting affirmative action as possible solution to eliminating perceived or actual racism in health services). Other commentators have advanced proposals for affirmative action in graduate medical education as a means of addressing racial disparities in care by increasing the numbers of black physicians. *See id.* (supporting premise that increase in minority students in medical schools may assist in solving problem of racial disparity in health care).

102. *See, e.g.*, K. Patricia McGann et al., *Absence of Sex Differences in the Evaluation of Patients Hospitalized for Transient Ischemic Attacks*, 39 J. FAM. PRAC. 134, 137 (1994) (finding that evaluation of elderly patients hospitalized for transient ischemic attacks did not differ significantly between men and women).

103. *See, e.g.*, Susannah C. Daly et al., *Cardiology Services After Stress Testing: Are There Sex Differences? A Population Based Study*, 53 J. CLINICAL EPIDEMIOLOGY 661, 663 (2000) (finding that in one-year period following cardiac stress testing, no difference existed between sexes in their use of either inpatient or outpatient/consultative cardiology visits, but that women were less likely to receive preventive cardiology visits).

104. *See, e.g.*, Lee A. Green & Mack T. Ruffin, *A Closer Examination of Sex Bias in the Treatment of Ischemic Cardiac Disease*, 39 J. FAM. PRAC. 331, 335 (1994) (finding that higher rate of hospital admissions for men at one hospital appeared to reflect overtreatment in men rather than undertreatment in women).

ences in medical needs. Unlike race, which is increasingly recognized as being a social construct rather than a biological fact,¹⁰⁵ biological differences do exist between the sexes. These biological differences lead to differences between the sexes in disease incidence, disease manifestation and effective disease treatment, and consequently play some role in contributing to differences in the diagnostic and therapeutic interventions provided to men and women.¹⁰⁶ Indeed, one criticism that women's health advocates level at the medical establishment is that medical research historically has failed to include women as subjects. As a result, there is a dearth of scientifically validated knowledge about sex differences and their clinical implications.¹⁰⁷ Because researchers excluded women, and particularly pregnant women, from research into a variety of conditions, doctors often do not know whether the findings from male-subject research are equally applicable to their women patients. This knowledge gap may force practitioners either to treat women as if they were men (which should not lead to disparities in use, but in some cases may be ineffective or dangerous because of biological differences) or to treat women differently based on their un-validated assumptions about sex differences (which would lead to disparities in usage, but still may not be effective care if the physician's assumptions are inaccurate).¹⁰⁸

Despite these complexities in determining which disparities in medical care utilization flow from biological differences in women patients and which flow from other causes, some research suggests that gender bias plays a role in producing some utilization disparities between women and

105. See Sandra Soo-Jin Lee et al., *The Meanings of "Race" in the New Genomics: Implications for Health Disparities Research*, 1 YALE J. HEALTH POL'Y L. & ETHICS 29, 33 (2001) ("The widely accepted consensus among evolutionary biologists and genetic anthropologists is that biologically identifiable races do not exist.").

106. See Council on Ethical and Judicial Affairs, *Gender Disparities in Clinical Decision Making*, 266 JAMA 559, 560 (1991) [hereinafter *Gender Disparities*] (stating that differences in biological needs between male and female patients most likely lead to their different use of health care services); Barbara M. Crawford et al., *Treatment Decision Making in Mature Adults: Gender Differences*, 21 HEALTH CARE FOR WOMEN INT'L 91, 92 (2000) (suggesting that gender differences in health care delivery may be explained by biological differences).

107. See Van Wijk et al., *supra* note 44, at 712 (explaining that exclusion of women from medical studies has allowed sex stereotypes to have more influence upon clinical decision making); see generally Rothenberg, *supra* note 12, at 1203 (reporting that exclusion of women in clinical research has impacted women's quality of health care).

108. See Van Wijk et al., *supra* note 44, at 712 (noting that "physicians applying the male model of ischaemic heart disease to women, may under diagnose ischaemic heart disease in women" and that another consequence of lack of information is that "sex stereotypes can have more influence upon clinical decision making"); see also John Z. Ayanian & Arnold M. Epstein, *Differences in the Use of Procedures between Women and Men Hospitalized for Coronary Heart Disease*, 325 NEW ENG. J. MED. 221, 223-24 (1991) (highlighting role that physicians' misperceptions regarding relative severity of coronary heart disease in men and women and regarding sex-related differences in risk and efficacy of interventions may play in producing different rates of procedures).

men. Before reviewing this evidence, however, a few broad distinctions regarding gender differences in health care utilization, as compared to racial differences, bear noting. The research shows that—in broad terms—utilization of health care services by African Americans lags behind that of whites with respect to most services, including primary care, preventive care and therapeutic interventions for treating acute and chronic illnesses such as cancer, heart disease and HIV/AIDS. Blacks, however, are more likely to be treated for preventable conditions and to be hospitalized for treatment of a condition (both measures indicate receipt of less than optimal levels of preventive or primary care). By contrast, women have been shown generally to consume more health care services than men, in terms of visits to doctors, laboratory tests and number of prescriptions written.¹⁰⁹

Thus, in many instances, sex-related disparities in health care services tilt in favor of women receiving more care than men. With respect to treatment of certain conditions including heart disease, renal disease and lung cancer, however, studies have shown women to receive fewer interventions.¹¹⁰ In addition, one study finds that, among patients with advanced illness, women (or their proxy decision makers) are twice as likely as men (or their proxies) to perceive that their doctor had recommended only “comfort care,” as opposed to more aggressive treatment of their illness.¹¹¹ But “comfort care” should not be confused with appropriate pain relief. Data from a number of studies indicate that women’s complaints of pain are more likely to be discounted by health care providers and less likely to be treated adequately.¹¹² Thus, in examining the evidence of possible gender bias in the receipt of health care services, it is particularly vital to remain attuned to the fact that more medical care is not always better

109. See *Gender Disparities*, *supra* note 106, at 559-60 (finding that “women seem to receive more care even when both men and women report the same type of illness or complaint about their health”). This may be explained by the fact that conventional medical wisdom is that, although men tend to die earlier than women, women tend to experience higher levels of ill health. See Sally MacIntyre et al., *Gender Differences in Health: Are Things Really as Simple as They Seem?*, 42 *SOC. SCI. & MED.* 617, 621-22 (1996) (describing this as “one of the most frequently made observations in medical sociology or social epidemiology,” but cautioning that this picture has become oversimplified and needs re-examination).

110. See *Gender Disparities*, *supra* note 106, at 560 (suggesting gender has influence over physicians when recommending several major diagnostic or therapeutic interventions).

111. See Marie F. Johnson et al., *Patients’ Perceptions of Physicians’ Recommendations for Comfort Care Differ by Patient Age and Gender*, 15 *J. GEN. INTERNAL MED.* 248, 251-52 (2000) (suggesting “[p]hysicians’ recommendations . . . may be a mechanism by which women receive less aggressive medical care, particularly if recommendations for comfort care can be generalized to the larger context of aggressive and non-aggressive medical care”).

112. See generally Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias against Women in the Treatment of Pain*, 29 *J.L. MED. & ETHICS* 13 (2001) (surveying studies reaching this conclusion).

care¹¹³ and to focus on the appropriateness of care provided by seeking to link differences in the receipt of care to actual or probable differences in outcome.

That said, let us briefly examine several areas in which studies have documented gender disparities in receipt of health services and have suggested that physician bias plays a role. Again, while the published literature is far more extensive than the findings described here,¹¹⁴ I chose the following two examples of disparity as particularly illustrative and suggestive of bias.

a. Disparities in Physician-Prescribed Activity Restrictions

The first example of disparity does not involve women utilizing a procedure at a lower rate than men, but instead involves women being prescribed a particular intervention more often than men. In a study published in 1997, a team of researchers tried to identify the underlying reasons for physicians' more frequent imposition of activity restrictions on women than men.¹¹⁵ In their study, the researchers found that—even when controlling for differences in patients' socio-demographic characteristics, health profile, main role responsibilities, patient illness behaviors and physician characteristics—the odds of a physician directing a woman to restrict her activity was 3.6 times higher than for a man.¹¹⁶

The researchers explored four competing hypotheses seeking to explain gender differences in medical care to determine whether any of the hypotheses could account for the study findings.¹¹⁷ The researchers con-

113. For example, female patients are twice as likely as males to seek treatment for depression. See Floyd, *supra* note 30, at 406 (stating that "majority of physicians are aware of the two-to-one female-to-male ratio of patients seeking treatment for depression"). One researcher, however, notes that a large number (30-50%) of women who are diagnosed as suffering depression may be misdiagnosed and suggests that physician bias may play a role in the misdiagnosis. See *id.* at 403 (suggesting that physicians may be biased during evaluations of females because research shows women are more likely than men to seek treatment for depression). A misdiagnosis of depression can have adverse results for a patient in at least two different ways: She will be exposed to the risks and burdens of treatment for depression without any prospect of benefit, and she will fail to receive effective treatment for the true cause of her symptoms. See *id.* at 403, 406 (explaining how physicians' beliefs about diagnostic base rates may influence medical judgments).

114. For further citations to this literature, see *Gender Disparities*, *supra* note 106, at 560; Johnson et al., *supra* note 111, at 248, 252; see also Lori A. Bastian et al., *Gender Difference in Care for Acquired Immunodeficiency Syndrome-Related Pneumocystis Carinii Pneumonia*, 8 *WOMEN'S HEALTH ISSUES* 45, 47-48 (1998) (reporting lower levels of prompt diagnosis of HIV infection and treatment for PCP among women hospitalized with AIDS-related PCP).

115. See Safran et al., *supra* note 21, at 711-15 (attempting to discover underlying support for physicians' bias in medical treatment).

116. See *id.* at 715 (revealing results of study).

117. The researchers described the four hypotheses as follows:

The *biological basis hypothesis* holds that gender-related differences in biophysiology result in greater susceptibility to illness among women. The

cluded that neither differences in the health profiles of the men and women patients nor their role responsibilities could explain the difference in rates of activity restrictions, but that both gender differences in illness behavior and physician gender bias appeared to contribute to the differential.¹¹⁸ The authors interpreted their findings that a larger differential existed among patients of male, older and subspecialist physicians as particularly suggestive of a role for attitudinal biases, and then explained how gender bias might operate in this context:

[A] societally based view of women as weaker and more vulnerable than men could incline physicians who have consciously or unconsciously adopted this view to advise activity restrictions for female patients more readily than for males. A devaluation of female role responsibilities might also make physicians less concerned about advising temporary activity suspension Attitudinal biases such as these may subtly and unconsciously influence physicians' perceptions of patients' preferences¹¹⁹

Thus, the authors concluded that their findings suggested that physicians' attitudinal biases influenced how the physicians interpreted patients' illness behaviors.¹²⁰

b. Disparities in Cardiac Care

Differences in the rates at which physicians have provided diagnostic and therapeutic interventions relating to heart disease for women, as compared to men, have been under study since the mid-1980s¹²¹ and disparity

fixed role hypothesis asserts that women's role responsibilities are more amenable to the temporary suspension required by sickness than men's. The *socialization hypothesis* posits that social conditioning begun in childhood makes females more attuned to symptoms, and more willing to respond to and report them than men. The *physician bias hypothesis* argues that societal biases shared by, though not necessarily unique to, physicians result in differential diagnosis and treatment of female patients.

Id. at 712 (providing four competing hypotheses concerning gender differences in health care).

118. *See id.* at 718-19 (studying contributing factors in male and female patients' likelihood to receive physician-prescribed activity restrictions).

119. *Id.* at 719.

120. *See id.* at 720 (asserting that both gender differences in illness and physician gender biases contribute to increased rates of prescribed activity restrictions for females). The authors did not address whether the influence of these attitudinal biases led to overuse of activity restrictions for women or underuse of activity restrictions for men. *See id.* (noting limitations of study). It seems reasonable to assume, however, that either conclusion could lead to adverse social and economic (in the case of over prescription for women) or medical (in the case of under prescription for men) effects on patients. *See id.* (discussing possible steps to reduce attitudinal biases in medical profession and prevent serious repercussions).

121. *See, e.g.,* Jonathan N. Tobin, *Sex Bias in Considering Coronary Bypass Surgery*, 107 ANNALS OF INTERNAL MED. 19, 19-20 (1987) (discussing study with unanticipated finding that women suspected of having ischemic heart disease are far less likely than men suspected of having disease to be referred for catherization); *see*

in cardiac care appears to represent the single most closely examined area of sex-related disparities.¹²² Although the evidence here is inconclusive regarding the frequency and pervasiveness of disparities and their causes, recent studies have identified sex-related disparities in cardiac care and have suggested a possible role for physician bias in contributing to those disparities.¹²³

In a recently published study, researchers examined the rates at which men and women diagnosed with coronary artery disease were provided with lipid-lowering therapy (LLT) for high cholesterol.¹²⁴ The researchers found overall a low rate of LLT among study participants, but found that “[t]he overall reduced rates of therapy were particularly noteworthy in women,”¹²⁵ despite similar baseline and arteriographic characteristics. Moreover, the research showed that significantly fewer women than men in the study succeeded in lowering their cholesterol levels. The researchers concluded that their results “provide evidence of considerable sex bias at academic medical centers in the United States and Canada.”¹²⁶

Another study demonstrates an apparent interaction between gender and race in influencing physician decisions regarding cardiac care. Researchers in a widely publicized and controversial study used video recordings of actors portraying patients complaining of chest pain in a medical interview setting in order to assess physicians’ recommendations for managing the chest pain.¹²⁷ The researchers found that the hypothetical pa-

also Ayanian & Epstein, *supra* note 108, at 222 (studying impact of gender on diagnostic or therapeutic interventions relating to heart disease).

122. See generally Stuart E. Scheifer et al., *Race and Sex Differences in the Management of Coronary Artery Disease*, 139 AM. HEART J. 848, 852-54 (2000) (discussing studies).

123. In addition to the studies described in the text, see Chiriboga et al., *supra* note 34, at 272 (suggesting that residual gender differences in use of procedures for heart attacks not attributable to differing clinical characteristics may be result of differences in physicians’ practice patterns or may represent bias in delivery of medical care).

124. See Michael Miller et al., *Sex Bias and Underutilization of Lipid-Lowering Therapy in Patients with Coronary Artery Disease at Academic Medical Centers in the United States and Canada*, 160 ARCHIVES INTERNAL MED. 343, 343-46 (2000) (discussing study).

125. *Id.* at 346.

126. *Id.*

127. See Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians’ Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618, 621-23 (1999) (demonstrating how physicians’ medical recommendations may differ among patients of different gender and race). The results of this study were reported by major print and television media. See Schwartz et al., *supra* note 50, at 279 (stating that study was reported in most major newspapers and featured on ABC’s Nightline). The coverage and the study authors’ presentation of their findings were criticized for suggesting that both race and gender were independent factors in contributing to lower levels of referrals for cardiac catheterization and for overstating their findings. See *id.* (discrediting results of study by highlighting that “the magnitude of the finding was overstated, the comparison report was incorrect and the implicit assumption—that catheterization always represented the best care—

tients (who all had identical histories, read their scripts verbatim and were directed to express a consistent range of emotions in their presentation) who were black women received referrals for cardiac catheterizations at a lower rate than white male patients, black male patients or white female patients.¹²⁸ In discussing their results, the researchers characterized their findings as suggesting that “a patient’s race and sex [or, more precisely, the combination of race and sex] may influence a physician’s recommendation with respect to cardiac catheterization regardless of the patient’s clinical characteristics,” but speculated that any bias was more likely to be the product of physicians’ “subconscious perceptions rather than deliberate actions or thoughts.”¹²⁹

c. What to Make of the Disparities: Does Gender Play a Role?

A statement made by the AMA’s Council on Ethical and Judicial Affairs in 1991 still rings true today: “Available data do not *conclusively* demonstrate a connection between gender bias and gender disparities in the provision of health care. Designing a study that can control for the myriad social, economic, and cultural factors that might influence decision making in a clinical context has proved extraordinarily difficult.”¹³⁰ Despite the lack of conclusive evidence, however, the suggestion of gender bias in clinical decision making is quite compelling and cannot be ignored. As with race, I do not suggest that all doctors are sexist and misogynist and deliberately provide different and less effective care for women. Instead, as with race, any bias is far more likely to be subconscious and unperceived by the practitioner, and is likely to be present in some providers but not in others.¹³¹ The effects of allowing patient gender (when gender is not related to medical need) to influence treatment decision making are real, however, and may operate to the detriment of either women or men. While the operation of subconscious gender bias seems likely to mimic that of unconscious race bias,¹³² researchers in this area have proposed that two factors may be particularly likely to interact in the context of treatment decisions for women.

was unwarranted”); *see also* SATEL, *supra* note 51, at 160-64 (discussing impact of study’s findings).

128. Black women were referred 78.8% of the time, while other patients were referred 90.6% of the time. *See* Schwartz et al., *supra* note 50, at 279 (interpreting Schulman’s reported referral rates).

129. Schulman et al., *supra* note 127, at 624.

130. *Gender Disparities*, *supra* note 106, at 561 (emphasis added).

131. *See* Green & Ruffin, *supra* note 104, at 335 (suggesting that disparities in cardiac care may be present in some hospitals, but not others, and that “question of sex bias is essentially one of medical decision-making”).

132. *See* Schulman et al., *supra* note 127, at 624-25 (finding that “subconscious bias occurs when a patient’s membership in a target group automatically activates a cultural stereotype in the physician’s memory regardless of the level of prejudice the physician has”).

First, as noted above, because women were historically left out of medical research, physicians treating women for many conditions have less scientifically based guidance than they do for their male patients. Thus, unless a physician simply assumes that findings from male-subject research are equally applicable to female patients, the physician is left to exercise his best judgment with respect to treatment of his female patients. In other words, because of the paucity of scientifically valid research regarding females with a variety of conditions, the treatment of female patients is more likely to be discretionary. And, as noted above in the discussion of racial disparities, situations in which treatment choices are discretionary or diagnostic determinations are uncertain create greater opportunities for a physician's own subjective perceptions or societal stereotypes to influence the decision made.¹³³

Second, there is no shortage of fairly consistent social stereotypes pertaining to women. Although women have made huge strides in the past four decades towards achieving greater equality and eroding gender-based stereotypes regarding their "place," gender-based norms and expectations persist quite robustly in American society. In the medical community, these expectations may be embodied in physicians' assumptions that women are less likely to choose aggressive interventions,¹³⁴ assumptions that women are less likely to have demanding social or career roles,¹³⁵ attributions of women's physical complaints to emotional or mental causes¹³⁶ and devaluations of women's contributions to society.¹³⁷ Each of these gender-based stereotypes could infect a physician's judgment regarding a female patient's diagnosis and her optimal treatment. While doctors are probably unlikely to flatly deny a female patient an aggressive and potentially effective therapy that she actively seeks, the physician's counseling of the patient to follow the course that the physician believes is in the pa-

133. See Floyd, *supra* note 30, at 406 (discussing role of bias in diagnosing depression in women); Safran et al., *supra* note 21, at 712 (finding "more pronounced gender-based treatment differential where PPAR is more discretionary"); Van Wijk et al., *supra* note 44, at 712 ("Another consequence of lacking knowledge is that sex stereotypes can have more influence upon clinical decision making.").

134. Cf. Crawford et al., *supra* note 106, at 98 (finding "no significant gender differences in hypothetical treatment decisions made by patients").

135. See, e.g., Hoffmann & Tarzian, *supra* note 112, at 19 (raising possibility that physicians may assume that men need more assistance with their pain because they have to support their household financially); Safran et al., *supra* note 21, at 719 (suggesting that devaluation of female role responsibilities might make physicians more likely to impose activity restrictions).

136. See Scheifer et al., *supra* note 122, at 854 (raising possibility that physicians may be likely to minimize symptoms in women and attribute them to emotional causes).

137. See Van Wijk et al., *supra* note 44, at 712 (suggesting societal values regarding gender roles may influence clinical decision making).

tient's best interest could easily provide the vehicle through which the bias operates.¹³⁸

5. *Evidence of Other Biases*

In addition to evidence strongly suggesting the existence of race and gender bias in clinical decision making, some (albeit much sparser) evidence exists indicating that other patient characteristics unrelated to a patient's medical need—such as age, sexual orientation, disability or obesity—may influence physicians' treatment decisions. This subpart will briefly describe some of this evidence in order to reinforce the concept that physician bias is not monolithic, but instead can wear many faces and present varying issues as the nature of the bias varies.

For example, a number of studies indicate that older patients are less likely to receive aggressive medical care than younger patients, even after controlling for the severity of the patients' illness.¹³⁹ This age-based disparity appears particularly strong in the context of aggressive treatments for advanced illness. One study found that among seriously ill, hospitalized adults, older patients were more likely than younger patients to have treatments such as surgery, dialysis and ventilator support withheld, even after adjusting for patients' preferences for life-extending care.¹⁴⁰ Another study found that patients over the age of seventy (or their proxy decision makers) were almost four times more likely than younger patients to believe that their doctor had recommended only comfort care for them, rather than life-sustaining treatment.¹⁴¹ Yet another study suggests a patient's advanced age would not by itself bias a doctor's treatment decision for a patient who had been functioning well mentally and physically before the onset of an illness, but that an older patient with pre-illness disabilities would likely be treated less aggressively than a younger patient with the same illness and similar pre-illness disabilities.¹⁴² Similarly, a survey of physicians who were questioned regarding their agreement with treatment choices for hypothetical patients revealed that a significant proportion of the respondents concurred in judgments to treat an older pa-

138. See Johnson et al., *supra* note 111, at 252 (noting that "physicians' recommendations, or the perception of them, may be a mechanism by which women receive less-aggressive medical care").

139. See *id.* at 248 (discussing age's effect on delivery of medical services).

140. See Mary Beth Hamel et al., *Patient Age and Decisions to Withhold Life-Sustaining Treatments from Seriously Ill, Hospitalized Adults*, 130 ANNALS INTERNAL MED. 116, 121 (1999) (discussing study).

141. See Johnson et al., *supra* note 111, at 252 (discussing study results).

142. See Alfred E. Stillman et al., *Are Critically Ill Older Patients Treated Differently than Similarly Ill Younger Patients?*, 169 W. J. MED. 162, 163 (1998) (discussing study results); see also Charles L. Bennett et al., *Patterns of Care Related to Age of Men With Prostate Cancer*, 67 CANCER 2633, 2633-41 (1991); Craig Fleming et al., *Is Coronary-Care-Unit Admission Restricted for Elderly Patients? A Multicenter Study*, 81 AM. J. PUB. HEALTH 1121, 1123-25 (1991) (discussing study results).

tient less aggressively than a younger patient, even when those patients' likelihoods of survival were identical.¹⁴³

Researchers have advanced several possible explanations for these age-related differences in care. One team suggests that physicians may recommend less aggressive treatment for older patients based on an erroneous belief that older patients are more likely to suffer poor outcomes or are less likely to benefit from aggressive treatment; this team, however, also recognizes the alternative possibility that the differences in care may reflect "a covert, and perhaps unintentional form of health care rationing."¹⁴⁴ Other researchers point to the possibility of "ageism, or discrimination based on chronological age" and suggest that this bias may reflect either society's values or the physician's own personal values and preferences.¹⁴⁵ Bolstering these suggestions are attitudinal surveys demonstrating that physicians subjectively associate "old age" with sickness and inactivity¹⁴⁶ and indicating that students in their first year of medical training have already formed negative impressions about older patients and how aggressively they should be treated.¹⁴⁷

What is perhaps most distinctive about apparent age-based bias in medical decision making is that some commentators view patient age—unlike patient race or gender—as a potentially legitimate consideration in making health care treatment decisions, even when age is unrelated to the individual patient's medical need or prognosis. Several scholars have argued that advanced age is a legitimate moral basis for rationing health care resources.¹⁴⁸ Others have responded that chronological age is an unjust and arbitrary basis for allocating resources.¹⁴⁹ It should be noted, however, that most proponents of age-based rationing argue for the adoption of explicit social policies implementing such a scheme; they do not advocate that individual physicians should covertly seek to ration care through their treatment decisions for older patients. Nonetheless, the un-

143. See Marie F. Johnson & Andrew M. Kramer, *Physicians' Responses to Clinical Scenarios Involving Life-Threatening Illness Vary by Patients' Age*, 11 J. CLINICAL ETHICS 323, 324-26 (2000) (discussing study results).

144. Johnson et al., *supra* note 111, at 253.

145. See Hamel et al., *supra* note 140, at 121-22 (noting factors that may explain disparities in health treatments).

146. See Norman Fineman, *Health Care Providers' Subjective Understandings of Old Age: Implications for Threatened Status in Late Life*, 8 J. AGING STUD. 255, 268 (1994) (suggesting that survey results indicate that physicians may expect older people to be incapable of being active and independent or incapable of recovering from illness).

147. See David B. Reuben et al., *Attitudes of Beginning Medical Students Toward Older Persons: A Five-Campus Study*, 43 J. AM. GERIATRICS SOC'Y 1430, 1433 (1995) (reporting research showing medical students had biases against elderly persons).

148. For the most prominent work advocating this proposition, see DANIEL CALLAHAN, *SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY* (1987).

149. See, e.g., Nancy S. Jecker & Robert A. Pearlman, *Ethical Constraints on Rationing Medical Care by Age*, 37 J. AM. GERIATRICS SOC'Y 1067, 1072-73 (1989) (presenting objections to rationing health care resources based on age).

resolved debate regarding age-based rationing highlights the complexity of the issues that age bias raises and suggests that physicians' choices of less aggressive care for elderly patients may reflect their personal belief in the legitimacy of age-based rationing.¹⁵⁰

A patient's sexual orientation may also bias a physician's medical judgment. Homosexuality remains socially stigmatized, and evidence suggests that some physicians share commonly held negative attitudes towards gay men and lesbians. Surveys indicate that many physicians feel uncomfortable treating gay men and lesbians and may even view homosexuality as an illness.¹⁵¹ These negative attitudes may bias a doctor's medical decisions so that a patient's sexual orientation influences the treatment provided even when sexual orientation is unrelated to the patient's medical needs. A 1994 study polled the membership of the American Association of Physicians for Human Rights (today called the Gay and Lesbian Medical Association) regarding how sexual orientation affects patients and doctors. Almost two-thirds of the physician respondents thought that a patient who disclosed his or her homosexuality to a doctor risked receiving substandard treatment, and about half had witnessed their colleagues (other physicians) providing reduced care or denying care to gay or lesbian patients.¹⁵² A patient's sexual orientation may influence a physician's clinical judgment not only by making the physician less willing to pursue aggressive treatment on the patient's behalf, but also by leading the physician to focus inappropriately on the patient's sexuality, thus interpreting the patient's problems in sexual terms rather than considering a full range of diagnoses.¹⁵³

Out of concern for the perceived likelihood of disapproval and substandard treatment, many lesbians and gay men are reluctant to disclose their sexual orientation to their physicians.¹⁵⁴ Herein lies an important distinction between bias based on gender, race or advanced age and bias based on sexual orientation. Because a patient's sexual orientation may not typically be a trait that is readily visible, patients must decide whether to divulge their sexual orientation to their physician and risk receiving

150. See Johnson & Kramer, *supra* note 143, at 326 (noting consistent relationship in study between responses to questions about allocation of aggressive care under other circumstances and limiting care for elderly persons).

151. See *Health Care Needs*, *supra* note 2, at 1356-57 (reporting that physicians may have biased attitudes towards gay men and lesbians that may affect medical treatment of these patients); Milton L. Wainberg, *The Hispanic, Gay, Lesbian, Bisexual and HIV-Infected Experience in Health Care*, 66 *MT. SINAI MED. J.* 263, 264-65 (1999) (describing surveys).

152. See Brian McCormick, *Anti-gay Discrimination Impedes Careers*, *Health Care*, *AM. MED. NEWS*, July 11, 1994, at 7 (discussing study). A Trustee of the AMA, William Jacott, MD, said: "[U]nfortunately, I think there is still quite a bit of bias." *Id.*

153. See Harrison & Silenzio, *supra* note 6, at 35 (citing study showing nurses and doctors are generally disapproving and distrusting of homosexuals).

154. See *id.* (stating that "many lesbians and gay men fear disapproval, compromised treatment, or physical harm if they divulge their sexual identities").

biased treatment. This fear regarding the consequences of disclosure appears to lead many gays and lesbians to respond in one of two ways, each of which may be quite detrimental to their health. Some may seek medical care but remain silent regarding their sexual orientation. While this silence may prevent a physician from inappropriately considering the patient's sexuality in exercising medical judgment, it also precludes the physician from considering the patient's sexual orientation in an appropriate (i.e., a medical-needs-related) fashion. Gay men and lesbians do have certain health needs that differ from those of the heterosexual population.¹⁵⁵ A physician who simply assumes that all her patients are heterosexual unless the patient discloses otherwise may thus "misdiagnose conditions, provide inadequate treatment, offer irrelevant health teaching, lecture needlessly about birth control, ask insensitive or biased questions, and make sexist remarks."¹⁵⁶

The other way that gay men and lesbian women may try to avoid biased treatment is to avoid medical care altogether. For example, one study showed that almost half of lesbians rarely or never visited a gynecologist. Gay men may also be less likely to seek preventive care than their heterosexual counterparts.¹⁵⁷ Thus, when we examine the problem of sexual orientation bias in medical care, we see that physician bias (particularly the more overt, expressed sentiments of disapproval and hostility that gay men and lesbians may face) can be pernicious for the subjects of the bias not only when the bias operates to corrupt medical judgment, but also when the subjects of the bias seek to avoid its operation. Effectively, the potential for bias can function as a barrier to accessing effective care for gay men and lesbians.

Two remaining patient characteristics that may influence medical decision making beyond any clinical relevance of the characteristic are patient disability and patient obesity. Although some evidence suggests that the process of medical education may improve students' attitudes towards persons with disabilities,¹⁵⁸ physicians at times still tend to focus their at-

155. *See id.* at 33 (noting that these special health considerations include not only STD's but also developmental differences); *see also Health Care Needs, supra* note 2, at 1354 ("Generally, men and women who engage in same-sex behavior have the same health afflictions as individuals who engage in opposite-sex behavior. Some diseases, however, are of particular concern to men and women who engage in same-sex behavior and therefore are important in a differential diagnosis and treatment plan.").

156. Harrison & Silenzio, *supra* note 6, at 35.

157. *See id.* at 36 (stating that gays and lesbians may avoid health care based on their fears of consequences of disclosing their sexual orientation).

158. *See* Mary Jean Paris, *Attitudes of Medical Students and Health-Care Professionals Toward People with Disabilities*, 74 ARCHIVES PHYSICAL MED. & REHABILITATION 818, 818 (1993) (noting that although studies show that attitudes of medical students toward disabled change during their training, results are inconsistent on whether they improve, deteriorate or stay the same). Past surveys of physicians and medical students, however, have shown a clear bias against persons with AIDS or HIV infection, who are typically deemed persons with a disability under the ADA.

attention on a patient's disability, rather than addressing her health needs more generally.¹⁵⁹ In addition, the well-publicized case of Sandra Jensen illustrates that physicians may be reluctant to pursue aggressive medical treatment for some persons with disabilities.¹⁶⁰ Physicians at two academic medical centers in California initially refused to place Sandra Jensen on a waiting list for a heart and lung transplant because they believed that a person with Down syndrome would not be able to comply with the rigorous post-transplantation regimen. Thus, physicians may allow the mere existence of a disability to influence their medical judgment without examining how the individual patient's disability affects her actual medical needs.¹⁶¹

As with physical and mental disabilities, obesity is a patient characteristic with potential health consequences that a physician may need to consider in order to address appropriately a patient's medical needs. Evidence suggests, however, that obesity in a patient may also stimulate strongly negative and judgmental reactions from physicians, just as it may from members of the general public.¹⁶² One result of such openly biased behavior is that obese persons, like gay men and lesbians, may be reluctant to seek medical treatment.¹⁶³ Beyond overt and conscious negative reactions to patients who are obese, however, physicians may also subconsciously incorporate negative social stereotypes regarding obesity into their medical decisions. A physician recently reflected in *The New York Times* on the possibility that his treatment of a patient with heart disease had been influenced by the patient's obesity. His words reflect the struggle involved in recognizing "camouflaged" bias:

See Wainberg, *supra* note 151, at 264-65 (discussing surveys of medical students). This discussion of disability bias does not focus on AIDS bias, however, because it may be particularly difficult to assert that a patient's HIV infection is clinically irrelevant to treatment decisions and because AIDS bias in many cases overlaps with and is difficult to assess separately from a physician's homophobia. *See id.* (discussing survey on attitudes toward gay men with AIDS or leukemia).

159. *See* David Doostan & Michael Wilkes, *Treating the Developmentally Disabled*, 171 W. J. MED. 92, 94 (1999) (discussing challenges people with mental retardation face in receiving appropriate health care and providing recommendations for improving health care to these patients). For a fuller report on problems in the health care received by persons with mental retardation, *see generally Closing the Gap: A National Blueprint to Improve the Health of Persons with Mental Retardation, Report of the Surgeon General's Conference on Health Disparities and Mental Retardation*, at <http://www.surgeongeneral.gov/topics/mentalretardation/retardation.pdf> (2002).

160. *See* Mary Crossley, *Becoming Visible: The ADA's Impact on Health Care for Persons with Disabilities*, 52 ALA. L. REV. 51, 65 (2000) (highlighting examples of biased medical treatment that physicians provide to patients with disabilities).

161. *Cf.* Doostan & Wilkes, *supra* note 159, at 93 (reporting that caretakers of persons with developmental disabilities may find that physicians do not support providing elective care to such patients).

162. *See* Leanne Joannise, *supra* note 3 (describing published studies and reporting results of her own interviews with obese people regarding their treatment by medical professionals).

163. *See id.*

It did not appear that our prejudice, if it existed, had been conscious. Granted, the patient's obesity had been on our minds in deciding on his treatment. But had we been hypersensitive about his obesity, to his detriment? Had we made a value judgment that because of his weight, surgery would be wasted? Or worse, that he was somehow less deserving of surgery because he was unable or unwilling to control his weight?¹⁶⁴

These words provide a fitting conclusion to our survey of the evidence regarding various forms of physician bias in medical practice. They begin to suggest the variety of ways that a characteristic of a patient may influence a physician's medical judgment beyond the characteristic's relevance to the patient's medical needs. The following section will consider what to make of the evidence that has been surveyed.

C. *Is this a Problem that Needs Fixing?*

Admittedly, none of the research just surveyed finds conclusively that physician bias is a cause of the numerous documented disparities in the levels of health care services received by members of minority groups or that a patient's gender, age, sexual orientation or other characteristic influences physicians' clinical decision making in any statistically significant way. Nonetheless, the growing number of studies that control or adjust for other possible factors that might explain disparities, combined with the studies of patients' perceptions of bias and anecdotal accounts of apparently biased treatments, collectively leave a firm impression that patient characteristics do indeed influence some significant number of medical decisions beyond any role that the characteristics' medical relevance might justify.

In some ways, this conclusion is anything but surprising. Assumptions and stereotypes based on race, gender, age and other characteristics remain powerful ingredients in today's society, and individuals' (often) unwitting reliance on prejudices and stereotypes in managing information and making decisions is a common human experience.¹⁶⁵ In other words, the "stereotypic expectancies" that have been unconsciously incorporated in a decision maker's general belief system can bias how the decision maker interprets information received, and the part played by bias is likely greater when the information processed is ambiguous.¹⁶⁶ Having been observed in a variety of fields and professions, bias and its effect on deci-

164. Sandeep Jauhar, *Hidden in the World of Medicine, Discrimination and Stereotypes*, N.Y. TIMES, June 19, 2001, at F6 (suggesting that medical bias still exists in camouflaged form).

165. Cf. Amy Wax, *Discrimination as Accident*, 74 IND. L. J. 1129, 1135-36 (1999) (reviewing work of cognitive scientists in "mental contamination").

166. See van Ryn & Burke, *supra* note 1, at 823 (indicating stereotypic expectancies can significantly bias how information is interpreted).

sion making are pervasive in human enterprise.¹⁶⁷ Why would we expect that physicians should be immune to this phenomenon any more than other humans?

One might surmise that physicians should be and are less likely than members of other professions or the general population to be influenced by group-based bias. Since physicians are highly educated and trained in the sciences, with a premium placed on objectivity, one could speculate that they might self-consciously strive for objectivity and factual bases for their diagnostic and treatment decisions. Likewise, because physicians' professional ethic directs them to focus on their patients as individuals and to be loyal to their patients' well being, we might hope that physicians as a group are more scrupulous than most people in examining their own motives in making decisions.

Other factors, however, weigh against a conclusion that physicians are less likely to allow bias to infect their judgments. The chance that bias will creep into a decision increases as the decision becomes more complex, more ambiguous and more subjective—in other words, as the decision requires the exercise of true judgment.¹⁶⁸ This observation is consistent with the findings discussed above in the context of both race and gender disparities, where disparities are greater when the treatment choices are more ambiguous and thus discretionary. Moreover, characteristics of contemporary health care delivery may increase the opportunities for bias to operate. With the rise of managed care patients today are less likely to have established long-standing relationships with their physicians, and physicians are less likely to have time to spend talking to their patients and getting to know them as individuals.¹⁶⁹ Each of these points indicates that

167. See Safran et al., *supra* note 21, at 720 (“The impact of socially acquired attitudinal biases on human interaction and decision making has been observed in every profession and every field from education to jurisprudence . . .”).

168. One commentator explains more thoroughly how bias can operate in diagnostic decision making:

A medical diagnosis is a statement about the disease in question, its natural course, its prognosis, its treatment, and its outcome. A physician's hypotheses about the nature of the female patient's physical, cognitive, and/or emotional complaints are expressed through diagnosis, and physicians may be subject to several biases that affect decision-making processes; these biases represent relatively permanent perceptual sets. When faced with an uncertain diagnostic determination, such pre-existing expectancies represent one of the most important determinants of interpreting women's presenting complaints. Judgment heuristics simplify and classify female patients' initial symptoms; they represent an attempt to manage the complexities of patient generated, disease-specific, and treatment information.

Floyd, *supra* note 30, at 403 (finding pre-existent physicians' biases cause problems in accurately diagnosing depression in female patients).

169. In her consideration of whether employment discrimination law under Title VII of the Civil Rights Act should be extended to instances of unconscious discrimination in employer evaluations, Amy Wax questions the applicability of laboratory findings regarding “mental contamination” to workplace evaluations. See Wax, *supra* note 165, at 1140 n.23 (noting studies to be “usually with a stranger,

physicians appear increasingly unlikely to obtain (and process) individualized information about a patient that could act to disconfirm a biased assumption.

Thus, it is implausible to conclude that the medical profession has succeeded in eliminating all influence of bias from its enterprise when the rest of society has not.¹⁷⁰ If we accept, based on the foregoing survey of the evidence, that physician bias based on patients' non-medical characteristics does influence medical decision making in some number of cases, then we must turn to questions of whether this operation of bias should be seen as wrong or inappropriate, and whether the existing legal system offers any responses to biased medical decision making. The following Parts turn to these tasks.

III. WHAT'S WRONG WITH BIASED MEDICAL DECISIONS?

Of course, even if one accepts that physician bias based on patients' non-medical characteristics sometimes influences medical decisions, one possible response is "so what?" After all, the influence of characteristics like race, gender, disability or sexual orientation on decisions in the social or economic life of our society may not always be viewed as wrong. Even when such influence is understood to be wrong or undesirable, it may not be seen as deserving legal intervention. This nonjudgmental—or at least noninterventionist—stance towards bias is most common in situations involving private or personal relationships. For example, the same civil rights laws that prohibit exclusionary policies by employers and public accommodations contain exemptions from their coverage for purely private clubs.¹⁷¹ One could argue that the physician-patient relationship is personal and confidential in nature and thus beyond the proper reach of laws addressing discrimination and bias. Strong arguments exist, however, that

for a period of an hour or less. And, of course, the laboratory studies primarily use college students as subjects."). One basis for Wax's questioning whether the experiments accurately reflect the reality of the workplace environment is that the experiments are based on encounters of an hour or less between the decision maker and a stranger. *See id.* While unlike an employer's evaluation of an existing employee, this sounds quite a lot like many modern medical encounters. *See* Jesse A. Goldner, *Managed Care and Mental Health: Clinical Perspective and Legal Realities*, 35 Hous. L. Rev. 1437, 1454-55 (1999) (discussing how short medical visits are often encouraged, and reporting average physician-patient sessions to last less than hour).

170. As the AMA's Council on Ethical and Judicial Affairs wrote in 1990, when the evidence of racial disparities was less overwhelming than it is today: "Disparities in treatment decisions may reflect the existence of subconscious bias Despite the progress of the past 25 years, racial prejudice has not been entirely eliminated in this country. The health care system, like all other elements of society, has not fully eradicated this prejudice." *See Black-White Disparities, supra* note 35, at 2346 (acknowledging that racial disparities in medical arena still exist).

171. *See* 42 U.S.C. § 2000a(e) (2001) (exemption under Title II of Civil Rights Act of 1964); 42 U.S.C. § 12187 (2001) (exemption under Title III of Americans with Disabilities Act).

the influence of physician bias on medical treatment decisions violates both the ethical and legal norms of the private physician-patient relationship and the public norms embodied in the civil rights laws. Let us turn to a brief articulation of those arguments.

A. *The Private Dimension of Biased Medical Judgments*

Although the physician-patient relationship may be understood as a personal and confidential relationship, it is nonetheless a relationship that exists within and is (at least theoretically) subject to well-developed ethical and legal norms. A fundamental premise of medical ethics is that a physician is obligated to act in her patient's best interests and to base medical decisions solely on advancing those interests. It is commonly stated that physicians should not allow outside influences to affect their decisions about what is best for their patients. It might also be said that physicians should not allow their own internal biases to affect decisions about their patients' treatment. Indeed, the American Medical Association (AMA) has addressed evidence of racial and gender bias in clinical decision making by including in its code of medical ethics express condemnations of such influences.¹⁷² Thus, organized medicine's official view is that at least some forms of bias are inconsistent with a physician's ethical obligations.

The wrongness of biased medical decisions can also be seen from a slightly different perspective. Not only may bias interfere with a physician's obligation to advance a patient's best medical interests, it also leads to a physician being disloyal to a patient in a fundamental sense. The physician-patient relationship is often characterized as a relationship of trust that is fiduciary in nature; in this light, the physician serves as a "trustee for the patient's medical welfare."¹⁷³ This obligation of loyalty and fidelity requires the physician to elevate the patient's well-being over any self-interest that the physician may have in a situation. While medical ethics recognizes that this obligation of loyalty is not absolute in all situa-

172. In its opinion entitled "Racial Disparities in Health Care," the AMA includes the statement: "Physicians should examine their own practices to ensure that racial prejudice does not affect clinical judgment in medical care." *AMA Policy Compendium* at E-9.121. The opinion entitled "Gender Disparities in Health Care" recognizes that a patient's sex may have legitimate implications for clinical judgments, but cautions:

Social attitudes, including stereotypes, prejudices and other evaluations based on gender role expectations may play themselves out in a variety of subtle ways. Physicians must ensure that gender is not used inappropriately as a consideration in clinical decision making. Physicians should examine their practices and attitudes for influence of social or cultural biases which could be inadvertently affecting the delivery of medical care.

AMA Policy Compendium at E-9.122. The AMA has not directly addressed the question of bias based on a patient's non-medical characteristics more generally. *See id.*

173. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 312, 312 (Oxford University Press 5th ed. 2000).

tions,¹⁷⁴ the physician who permits personal biases to influence his medical judgment is not maintaining the focus on patient welfare that professional fidelity requires.¹⁷⁵

Aside from the lofty aspirations expressed in medical ethics codes, the more mundane law of medical malpractice also regulates the relationship between physician and patient, requiring that the physician exercise due care in advising and treating patients. The standard of care in medical malpractice actions is typically articulated as a professional and customary standard of care.¹⁷⁶ Thus, a physician must treat his patients as physicians customarily do under the circumstances. Consequently, if personal bias leads a physician to treat a patient in a manner that falls below the professional standard of care and the patient suffers injury as a result, the physician may be liable. In this scenario, however, the reason for the substandard care (here, bias) is irrelevant; the focus is simply on the quality of care delivered.

The nature of a physician's ethical and legal obligations to her patients has received renewed attention over the past decade as the growth of managed care delivery systems has generated perplexing questions about the conflicts of interest a physician may face in treating managed care enrollees. Managed care plans often incorporate financial incentives for the physician to make cost-conscious diagnostic and treatment choices. Put more bluntly, the physician is paid more for providing less expensive care.¹⁷⁷ Such methods of reimbursement may create a conflict between the patient's best medical interests and the physician's financial self-interest.

A debate has taken root in the medical and legal literature about how to properly view these conflicts of interest: Should they be seen as violating the ethical precepts requiring a doctor to act loyally and solely in the patient's best interests? Or does our understanding of the nature of the physician-patient relationship require revision in light of changes in the world of health care financing and delivery? While some commentators argue

174. See M.Gregg Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, 281 JAMA 268, 269 (2001) (suggesting that physicians owe their patients undivided commitment, yet recognizing that clinicians face conflicting patient expectations).

175. See BEAUCHAMP & CHILDRESS, *supra* note 173, at 312-13 (recognizing that there may be competing moral obligations that limit and override obligations of fiduciary relationship).

176. See BARRY R. FURROW ET AL., *HEALTH LAW* at 264-65 (2d ed. 2000) (discussing standard of care in medical malpractice cases).

177. These financial incentives may take the form of capitated payment systems (in which a physician is paid a predetermined fee for each patient assigned to the physician's practice) and risk pooling arrangements (in which payments for specialty referrals and hospitalizations are deducted from a pooled amount of money and the physician receives some or all of any amount remaining in the pool after a set time period), among others. See Mary Ann Bobinski, *Autonomy and Privacy: Protecting Patients from their Physicians*, 55 U. PITT. L. REV. 291, 305 (1994) (discussing how incentives encourage physicians to deny patients treatment or referral).

that the conflicts of interest posed by managed care's financial incentives create an intolerable incentive for the physician to profit at the patient's expense,¹⁷⁸ others contend that disclosure of the conflict to the patient can adequately ameliorate any risks posed by the conflict.¹⁷⁹ Yet others argue for a reconceived understanding of the physician-patient relationship, an understanding that accepts some carefully bounded financial incentives as ethically legitimate.¹⁸⁰

Are these questions, regarding the survival of the ethical ideal of a physician's single-minded focus on patient well-being in the face of an assault by managed care payment methodologies analogous to questions about the tolerability of physician bias based on patients' non-medical characteristics? A shared inquiry, after all, is whether a factor other than the patient's welfare (whether that factor is the physician's own financial welfare or the physician's personal biases) can legitimately influence medical treatment decisions. Perhaps, one might argue, if the individual-patient-centered ideal of professionalism is crumbling in the face of managed care's focus on cost containment and population health, then that ideal may no longer be sufficiently robust to demand the elimination of personal biases from physician decision making.

The resemblance between the two situations, however, quickly dissolves upon consideration. The debate regarding physicians' professional obligations in a changing health care financing and delivery system seeks a proper balance between two goods. Doctors, lawyers, ethicists and policy-makers all seek to determine when the good of single-minded patient-centeredness should yield somewhat to the conflicting good of containing health care expenditures. It is critical to note that in this debate, commentators deem that containing health care expenditures on an individual patient is a "good" when it permits more cost-effective and broader deployment of health care resources—not when it simply creates fatter profits for managed care investors. In other words, the debate does not diminish the weight attached to professional values of patient-centeredness and loyalty; those values are simply weighed against other identifiable "goods."

By contrast, identifying any "good" that flows from the unimpeded operation of physician bias is difficult. The most that can be said on be-

178. See MARC A. RODWIN, *MEDICINE, MONEY AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 152-62 (1993) (noting how some financial incentives encourage self-interested behavior of physicians and have detrimental effects on patients' welfare).

179. See Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 762-63 (1994) (explaining how financial incentives reward physicians for withholding admittedly beneficial care and create economic conflict of interest between doctors and patients, yet if patients are informed of proposed incentives this conflict may be alleviated).

180. See, e.g., Mechanic, *supra* note 15, at 102 (arguing for "new professionalism" in response to "a growing disjunction between the traditional concept of medical professionalism and the changing circumstances of health care provision").

half of the physicians' personal biases is that human nature allows for such biases to exist and operate.¹⁸¹ The mere commonness of biases in the broader society, however, hardly qualifies the operation of physician biases as a "good" that could outweigh the ideals of professional fidelity and patient-centeredness. Indeed, it is because human nature often leads individuals to stray from the desired path, that professionals like doctors adopt codes of ethics. Thus, in contrast to the benefits that cost containment may promise, the operation of physician bias offers no "good" capable of outweighing a physician's obligation to act solely in the interests of his patients. This obligation, which inheres in the private relationship between physician and patient, provides one basis for rejecting biased medical judgments.

B. *The Public Dimension of Biased Medical Judgments*

Not only are biased medical decisions inconsistent with norms governing the personal relationship between doctor and patient, they may also impair widely held political values of justice and equal opportunity. Biased medical decisions are a piece of a much larger picture of health disparities existing between different racial, ethnic and socioeconomic groups in our society. Good health is an instrumental good that enables an individual to pursue other social, economic and personal goals. Ill health, on the other hand, threatens individual economic and social well-being. Consequently, inequalities in the distribution of health among different groups are often viewed as unjustly hindering the less healthy group in achieving not only its maximum health potential, but also its maximum social and economic potential.¹⁸² Admittedly, the role that biased clinical decisions in individual cases plays in creating pervasive health disparities is probably not as significant as the role that socioeconomic disadvantage and other systemic factors play.¹⁸³ Nonetheless, as Gregg Bloche suggests, a disparity that results directly from racial or other forms of bias may be particularly offensive to our sense of justice even in a society where socioeconomic disparities are broadly tolerated.¹⁸⁴

181. See *infra* note 339, at 1187-88 (suggesting cognitive theorists believe it is natural that stereotyping occurs when physicians are provided with information).

182. See generally Fabienne Peter & Timothy Evans, *Ethical Dimensions of Health Equity*, in CHALLENGING INEQUITIES IN HEALTH: FROM ETHICS TO ACTION 25 (Timothy Evans et al., eds. 2001) (discussing how moral philosophy can inform judgments about health equity).

183. See Bloche, *supra* note 9, at 97 ("Epidemiological research in the United States and abroad indicates that health care is only modestly important as a determinant of population-wide health.").

184. See *id.* at 98 ("Racial disparities in access to health care . . . due to differences in insurance coverage are more 'acceptable' than up front racial bias at the bedside, despite the correlation between coverage status and race."); cf. Peter & Evans, *supra* note 182, at 31 (suggesting approach by which "inequities that arise from deliberate discrimination may be judged as most pernicious and therefore deserving most attention compared with those that arise from passive neglect").

If biased clinical judgments result in one group of people receiving medical treatment different from that received by other groups, then members of that group may receive care that is less likely to effectively advance their medical interests. In other words, members of one group may receive suboptimal medical care because of their group membership. Thus viewed, the operation of bias in medical decision making, presents an issue of distributive justice because the operation of medical bias produces treatment differentials that likely result in health inequalities, which in turn may perpetuate social and economic inequalities. If the group whose members are the subject of biased medical decisions is defined racially, ethnically or in a way that has received civil rights protection, then biased medical decisions also present a civil rights challenge. Therefore, biased clinical decisions take on the cast of prohibited discrimination, rather than simply some breach of physician-patient protocol.

Moreover, as suggested in the Introduction, patients' perception of medical bias may have a negative impact on a societal level by decreasing group members' level of trust in the medical profession and health care system. For example, a reluctance on the part of African Americans to seek mental health care, because of a fear of misdiagnosis or inappropriate treatment, will lead to under-treatment of mental illness and to African Americans' "suffer[ing] a disproportionate burden of mental illness."¹⁸⁵ This unwillingness of members of some groups to seek medical attention may both hinder the health promotion and disease prevention efforts of public health authorities and contribute to a poorer overall health status for group members.

In sum, the operation of bias in medical decisions is a matter of public concern on several levels. Biased decisions can contribute to inequitable health disparities, which in turn may reinforce social and economic disparities. In addition, if the group of patients who are the victims of biased decisions correlate with persons protected by civil rights laws, then biased medical decisions also raise civil rights concerns. Finally, the "trickle down" effect of individual biased medical decisions may produce groups within society whose members are distrustful of the health care system. These effects demonstrate that the harm flowing from biased medical decisions is not limited to the immediate doctor-patient relationship.

This discussion demonstrates on a basic level why the operation of physician bias in clinical decision making is problematic and inappropriate in both its private and public dimensions. The character of the wrong, however, varies depending on whether a private or public perspective is adopted. The two primary avenues of potential legal response to the operation of physician bias, which the following Parts will discuss, track this distinction between the private and public natures of the wrong.

185. Erica Goode, *Disparities Seen in Mental Care for Minorities*, N.Y. TIMES, Aug. 27, 2001 at A1.

IV. PHYSICIAN LIABILITY FOR VIOLATING PROFESSIONAL DUTIES

If we understand biased medical decisions as violating a physician's professional and ethical obligations to her patients, does any effective legal remedy exist? This Part will consider whether the law of medical malpractice, informed consent or fiduciary duty might provide an avenue of legal recourse to a patient whose physician's treatment recommendation was biased. The argument that a biased medical decision theoretically violates a physician's professional duties to a patient, is fairly straightforward. Proving in court that a particular decision was in fact biased, causing the plaintiff compensable harm, is likely to be more difficult.

A. *Recovery for Medical Malpractice*

In a medical malpractice action, the plaintiff alleges that the medical care provided by his physician failed to conform to the standard of care and, as a result, caused him injury. Specifically, the plaintiff must prove through expert testimony that the physician's actions were not consistent with the professional or customary standard of care for treating patients with the plaintiff's condition.¹⁸⁶ How might medical malpractice liability—which essentially sounds in negligence—be an appropriate remedy for a physician's biased decision?

A biased clinical decision can be characterized as medical malpractice in a couple of ways. If bias relating to a clinically irrelevant characteristic of a patient leads the physician to provide treatment inconsistent with how physicians customarily treat the patient's condition, then a medical malpractice action is readily available to compensate the patient for any resulting injury. For example, let us imagine that the standard of care requires a physician to provide further diagnostic testing to a patient whose chest pain and stress test results indicate some cardiac abnormality, but that a particular physician's bias against African Americans leads him to order no further testing for an African-American patient.¹⁸⁷ If the patient subsequently suffers a heart attack due to an undetected and untreated heart condition, he can argue that the doctor's failure to conform to the standard of care was a proximate cause of the injuries. Note in that case, however, bias need not be alleged or proved. The cause of the physician's failure to act according to the standard of care is not at issue; the mere

186. The courts have traditionally applied a customary standard of care in medical malpractice actions, requiring that the jury judge the defendant's conduct not by the standard of what a reasonable person would do in the situation, but by what physicians actually do in the situation. See Philip G. Peters, *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 164-65 (2000) (explaining that relevant inquiries, under custom-based standard of care, include whether physicians acted in conformance with customary practices). In the past few decades, however, courts in a number of jurisdictions have moved away from the customary standard and towards a "reasonable physician" standard. See *id.* at 180-81 (discussing states adopting reasonable physician standard of care).

187. Cf. Schulman et al., *supra* note 127, at 621-23 (employing similar hypothetical).

fact of that failure is sufficient to support liability for economic and emotional harms flowing from the failure. It bears emphasizing that in this scenario the patient recovers for negligent medical treatment, not for biased medical treatment. In other words, the legal wrong addressed here is the physician's negligence—whatever its cause—rather than the physician's bias.

What about the case in which (to follow on the hypothetical already suggested) the physician does not fail entirely to provide further testing? Instead, let us imagine that the doctor has several diagnostic tests or procedures to choose from, which vary in cost, risk, invasiveness and overall effectiveness. Assume that the doctor—who typically chooses the newest, high tech, expensive procedure for his white patients—makes a biased choice for his African-American patients of a diagnostic test that is less invasive, less risky, less expensive and overall less effective. The test does not reveal the patient's heart condition, and the patient suffers a heart attack that might have been preventable. Does this patient have a medical malpractice claim?

The problem here is how to determine what the professional standard of care requires. The question is complicated with respect to many medical conditions because no single diagnostic or treatment modality constitutes the definitive standard of care. Instead, physicians as a group may employ a variety of different approaches depending on the patient's clinical characteristics, the patient's insurance coverage, the physician's level of experience with the different options and the physician's own practice style. Add an ever-changing medical technology to the mix, and defining any "customary" standard of care becomes quite difficult.¹⁸⁸ Consequently, the applicable professional standard of care for a particular medical condition may comprise a number of different diagnostic or therapeutic approaches. Indeed, an expert witness for the defendant doctor in our hypothetical might well testify that a choice of any of the follow-up diagnostic tests available to the doctor would have satisfied the profes-

188. Indeed, James Henderson and John Siliciano have argued that these very factors may prevent the formation of a common understanding among physicians on which the development of professional custom depends. They argue:

The variance within the patient population is matched by a diversity of therapeutic responses. Although health care providers of a generation ago may have had only a limited array of options in the diagnosis and treatment of illness and injury, the growth of technology in recent years has greatly added to the number of possible responses. Many medical conditions can now be treated in a wide variety of ways each with different costs, risks, and benefits New technologies represent new ideas that take time to absorb and master, thus undermining the kind of informational homogeneity that permits custom formation. Some actors will quickly integrate new approaches while others will cling to old ways, creating a disparity of understanding and practice that is corrosive to custom.

James A. Henderson, Jr. & John Siliciano, *Universal Health Care and the Continued Reliance on Custom in Determining Medical Malpractice*, 79 CORNELL L. REV. 1382, 1390-91 (1994).

sional standard of care and, therefore, it was within the physician's discretion to choose among them.¹⁸⁹ If that's the case, then our patient-plaintiff cannot successfully argue that the physician's chosen intervention violated the customary standard of care.¹⁹⁰

However, could the patient argue instead that the defendant's failure to conform to the standard of care lay in permitting bias based on a clinically irrelevant characteristic to influence his judgment? The argument would be that doctors do not customarily take the patient's race into account when deciding what diagnostic tests to perform, and therefore the operation of bias in this doctor's decision making deviated from the professional standard of care. Assuming that the plaintiff can prove that racial bias in fact infected the cardiologist's judgment,¹⁹¹ this argument has some appeal. After all, it seems doubtful that the defendant will be able to find an expert to testify that physicians' decisions regarding cardiac testing are customarily influenced by the patient's race.

The difficulty with this argument is that courts' focus in medical malpractice actions is on whether the defendant's *conduct* deviated from the standard of care, not on the defendant's motivation or decisional processes.¹⁹² For example, in a recent malpractice action alleging that a

189. *See id.* at 1394 ("For a given medical condition, tort law may not observe a single customary response, but may instead find diverse responses by providers, ranging from folk remedies to experimental cures.")

190. As Gregg Bloche notes: "Disparities in clinical resource use ensuing from physician discretion . . . tend to fall within the bounds of tacitly accepted clinical variation. Lower intensity care provided to a minority patient can thus typically be defended as consistent with one or another widely accepted standard of care." Bloche, *supra* note 9, at 109 (stating that medical malpractice cases normally turn into battle of expert witnesses over reasonable standard of care).

191. Not typically a safe assumption, as will be discussed *infra* Part IVD1.

192. *Lancaster v. Kaiser Found. Health Plan of Mid-Atl. States*, 958 F. Supp. 1137, 1146 (E.D. Va. 1997).

[M]edical malpractice plaintiffs need only show that a deviation from the standard of medical care occurred; they are not required to show why it occurred. A health care provider's deviation from the standard of care is actionable whether it was occasioned by inadvertence, ignorance, mistake, superstition, or indeed for any reason at all.

Id. at 1146. A somewhat analogous question has arisen regarding the admissibility in medical malpractice actions of financial incentives to provide less expensive health care. *See* Paul R. Sugarman & Valerie A. Yarasus, *Admissibility of Managed Care Financial Incentives in Medical Malpractice Cases*, 34 *TORT & INS. L.J.* 735, 751 (1999) (examining representative cases on admissibility of financial incentives in medical malpractice suits). These commentators note that courts that have considered the admissibility question are divided. *See id.* at 751-55 (discussing decisions showing that courts apply differing standards of admissibility regarding financial incentives in medical malpractice actions). Financial incentives are arguably relevant in some malpractice cases in proving that the plaintiff's account of the defendant-physician's actions is more likely to be factually accurate, as compared to the defendant's account of those actions. *See id.* at 755-56 (noting that courts allow plaintiffs to infer financial motivation from circumstantial evidence). In other words, in some cases evidence of financial incentives may help the plaintiff persuade the trier of fact that the defendant's conduct deviated from the standard of

physician's sexual relationship with a patient deprived him of the objectivity needed in the patient's treatment, the Oregon Supreme Court held that evidence of the sexual relationship was irrelevant to the medical malpractice claim. The court emphasized the objective nature of the professional standard of care, reasoning that the standard

provides no ground for delving into a physician's subjective state of mind. Physicians may violate their *ethical* duties if they fail to maintain the requisite clear and objective state of mind—for example, if they work while intoxicated or while their judgment is clouded by a relationship with a patient. But if, despite their less than optimal mental and emotional condition, their actual treatment of a patient reflects the appropriate degree of care, they cannot be held liable in negligence.¹⁹³

Therefore, unless the bias-influenced treatment choice falls outside the standard of care, the decision will not be grounds for a successful medical malpractice action. Thus, even if the plaintiff can show that, but for his race, his doctor would have chosen a different diagnostic approach (also within the standard of care) that would have been more likely to detect his condition and permit preventive care, the plaintiff will still lose because he has not shown the defendant failed to conform to the standard of care.

Finally, an even bleaker litigation prospect faces the plaintiff who seeks to sue his physician alleging medical malpractice, but who has not suffered any concrete injury as a result of the physician's biased decision. Again following on our hypothetical, let us assume that the doctor's bias influences him to choose a diagnostic procedure different from the one that he typically chooses for his white patients. In this case, however, the diagnostic test reveals the patient's heart condition and the patient receives appropriate preventive treatment. Nonetheless, the patient somehow learns that his doctor's choice was biased and, as a consequence, feels disrespected and betrayed. This patient is almost certainly unable to recover for medical malpractice, which typically does not award damages for purely dignitary harms.¹⁹⁴

In sum, traditional medical malpractice law is unlikely to provide an effective avenue for redressing the influence of physician bias on medical

care. *See id.* (discussing when financial motive evidence is relevant). This use of evidence of motive is different from arguing that the very existence of a particular motivational factor (be it bias or financial conflict of interest) constitutes a deviation from the standard of care. *See id.* at 759 (recognizing that evidence of financial incentives is routinely admitted by courts to "shed light" on events).

193. *Macy v. Blatchford*, 8 P.3d 204, 208 (Or. 2000) (affirming that standard of care requires physicians to use degree of care, skill and diligence used by ordinarily careful physicians in similar circumstances).

194. Recovery for dignitary injuries in tort actions has generally been limited to "recognized torts that involve some confrontation with the plaintiff in person or some indirect affront to his personality." DAN B. DOBBS, *LAW OF REMEDIES* § 7.1(1) (2d ed. 1993).

decisions. If the bias simply affects the physician's exercise of discretion among a number of clinical options, all of which are within the standard of care (as the medical literature discussed in Part II suggests it often may),¹⁹⁵ the physician's conduct will not be found to deviate from the standard of care and no liability will follow. Physician liability is probable only if the biased decisions produce conduct failing to conform to the customary standard of care, in which case, the fact of bias is irrelevant to the imposition of liability.

B. *Liability for Failure to Obtain Informed Consent*

An alternative avenue of relief for some patients alleging biased medical decisions is an action claiming a failure to obtain informed consent. Informed consent doctrine generally requires that a physician, prior to providing any kind of therapeutic or diagnostic care to a patient, inform the patient as to the nature and purpose of the proposed care and any non-remote risks associated with the treatment.¹⁹⁶ Courts initially treated a failure to obtain informed consent as a form of battery (since the patient had not consented to the physician's touching). Most jurisdictions today, however, treat informed consent claims as a form of medical malpractice in which the physician's disclosure to the patient is measured against the standard of care.¹⁹⁷

How could a biased medical decision give rise to an informed consent claim? Cases alleging biased medical decisions would not seem particularly likely to involve a total absence of patient consent, but might comprise a claim of inadequate physician disclosure. Specifically, in some cases the patient might assert that the physician, in recommending the proposed treatment, did not discuss other options. Informed consent doctrine requires a physician not only to advise the patient regarding the proposed treatment, but also to disclose the risks and benefits of viable alternative treatments or diagnostic options.¹⁹⁸ In the hypothetical case of the cardiac patient discussed above, if the doctor failed to tell the patient

195. See generally, *supra* note 36 and accompanying text.

196. See FURROW ET AL., *supra* note 176, at 315 (stating that health care provider must disclose various factors to satisfy elements of informed consent doctrine).

197. Cf. *Wuerz v. Huffaker*, 42 S.W.3d 652, 656 (Mo. Ct. App. 2001) (noting inconsistency between battery cause of action, which requires showing of total absence of consent, and action alleging negligence in obtaining consent, which requires showing that consent to procedure was given). For an account of the evolution of informed consent doctrine from battery to negligence, see *Martin v. Richards*, 531 N.W.2d 70, 75-78 (Wis. 1995) (concluding that growing number of courts hold that informed consent doctrine requires physicians to disclose what reasonable person in patient's position would want to know).

198. See *Martin*, 531 N.W.2d at 78 (holding that under informed consent doctrine if there is any chance patients will suffer very serious consequences possibly leading to death, it is physicians' duty to inform patients as to alternative treatments). *But cf. Schiff v. Prados*, 92 Cal. App. 4th 692, 701 (Cal. Ct. App. 2001) (stating that "there is no general duty of disclosure with respect to *nonrecommended*

that other diagnostic tests were also available as follow-ups to the stress test, the patient could allege that the failure to make that disclosure was negligent.¹⁹⁹

The informed consent plaintiff, however, cannot recover simply by showing a negligent failure to disclose alternatives. He must also show causation by proving that if adequate disclosure had been made, he would have opted for an alternative diagnostic or treatment choice and would thereby have avoided injury. In other words, our cardiac patient would have to prove that if his doctor had described to him the riskier, higher tech diagnostic procedure, he would have demanded that intervention, rather than the one recommended by his doctor, *and* that as a result his heart attack would have been avoided. Thus, proving causation can be particularly challenging in an informed consent action. Moreover, recovery on a negligent disclosure claim (as with a negligent treatment claim) does not depend on any showing of bias, but only on the doctor's failure to conform to the standard of care. Consequently, even a plaintiff who can put forward the proof necessary to recover on a negligent disclosure claim is not directly vindicating his right to receive *unbiased* medical advice.

C. *Liability for Breach of Fiduciary Duty*

Based on the foregoing, medical malpractice law seems generally unconcerned about the subjective aspect of physicians' clinical judgments and thus would seem to provide no remedy for the operation of bias in medical decision making. A limited exception to this general rule is suggested in those cases where a patient alleges a physician's failure to disclose to the patient conflicts of interest the physician faces in making therapeutic decisions. These claims object to the physician's failure to conform to the ethical principles that undivided loyalty to a patient should guide a physician's decisions, and that any influence on a physician's decisions—other than the patient's welfare—must be disclosed to the patient. Thus, the fiduciary nature of the physician's obligation to the patient brings into focus the subjective motivations for the physician's choices.

Indeed, the decision of the California Supreme Court in *Moore v. Regents of the University of California*,²⁰⁰ wedded the concepts of informed con-

procedure") (emphasis in original) (citing *Vandi v. Permanente Medical Group, Inc.*, 7 Cal. App. 4th 1064, 1071 (Cal. Ct. App. 1992)).

199. See, e.g., *Bethea v. Coralli*, 546 S.E.2d 542, 544-45 (Ga. App. 2001) (finding that physician's failure to disclose availability of diagnostic procedures less invasive than cardiac catheterization may give rise to action for medical malpractice under informed consent statute); see also Barbara A. Noah, *The Invisible Patient*, 2002 Ill. L. Rev. 121, 141-47 (advocating the use of informed consent doctrine to ensure that all relevant treatment options are conveyed to patients).

200. 793 P.2d 479, 483 (Cal. 1990), *cert. denied*, 499 U.S. 936 (1991) (emphasizing that physician has fiduciary duty to disclose all information material to patient's decision, including physician's personal interests that may be unrelated to patient's health).

sent and the disclosure obligation flowing from a physician's fiduciary duty. The plaintiff, Moore, sought treatment for his hairy-cell leukemia at UCLA Medical Center. In the course of treating Moore for the leukemia, his physician, Dr. Gold, withdrew samples of Moore's blood, bone marrow aspirate and other bodily substances, and ordered the removal of Moore's spleen. Unbeknownst to Moore, however, Dr. Gold knew that the cells removed from Moore's body could be substantially valuable to researchers seeking to commercially develop cell lines.²⁰¹ The court upheld Moore's action against Dr. Gold for failing to disclose his research and economic interests in Moore's cells before obtaining Moore's consent to the procedures by which those cells were removed. The court explained that the cause of action could be characterized "either as the breach of a fiduciary duty to disclose facts material to the patient's consent or, alternatively, as the performance of medical procedures without first having obtained the patient's informed consent."²⁰²

Thus, the California court characterized a physician's relationship to the patient as fiduciary in nature and stressed that the fiduciary obligation required the physician's disclosure of "personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment."²⁰³ While not holding that the mere existence of potential conflicts of interest breached the physician's fiduciary duty, the court noted that a reasonable patient would want to know of such conflicts in deciding whether to consent to a recommended procedure because of the possibility that "a physician who does have a preexisting research interest might, *consciously or unconsciously*, take that into consideration in recommending the procedure."²⁰⁴ Thus, according to the Court, the physician's fiduciary obligation requires, at a minimum, that he inform patients of any subjective motives that might influence his professional judgment.

By implicitly recognizing that a physician's professional judgment should not be influenced by considerations unrelated to the patient's health, *Moore* suggests that pursuing a cause of action for breach of fiduciary duty may prove more fruitful than a regular medical negligence action for a patient complaining of biased medical decisions. But does a physician stand in a fiduciary relationship to his patients? The law of fiduciaries applies to relationships in which one party (the fiduciary) is entrusted to use power or property for the benefit of another; this entrustment is often based on the fiduciary's specialized knowledge and requires the fiduciary

201. *See id.* at 481-82. Only a few years after the splenectomy, the Regents of the University of California applied for a patent on the cell line derived from Moore's white blood cells and named Dr. Gold as one of the inventors. *See id.*

202. *Id.* at 483.

203. *Id.*

204. *Id.* at 484 (emphasis added) (distinguishing situation where physician had no pre-existing plans to conduct research on patient's cells when medical treatment was recommended).

to exercise judgment in order to advance the interests of the other, who is typically unable to supervise adequately the fiduciary's performance.²⁰⁵ Based on this combination of factors involving entrustment, expertise and dependence, courts may conclude that a relationship is fiduciary in nature and, as a result, hold the fiduciary to the highest standard of conduct.²⁰⁶ The characteristics described typify the physician-patient relationship, and both commentators²⁰⁷ and the courts²⁰⁸ have recognized the physician's relationship to her patients as being fiduciary in nature. Although characterizing a physician as a fiduciary for his patients deviates somewhat from the typical understanding of a fiduciary as one who holds the financial interests of another in trust,²⁰⁹ the physician's fiduciary duty is a fitting legal analog to the physician's ethical duty to act with undivided loyalty in pursuing the patient's best interests.

Despite this broad agreement that a physician's relationship to her patients is fiduciary in character, the specific nature of the resulting obli-

205. See Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 243-44 (1995) (providing legal definition of fiduciary).

206. Although fiduciary obligations are sometimes imposed on specific relationships by statute, courts also determine fiduciary status on a case-by-case basis when the relationship is not statutorily defined. See *id.* at 244-45 (explaining decision making process courts apply when determining whether to recognize relationship as fiduciary). No bright-line test exists for determining the presence of a fiduciary relationship; "courts and commentators tend instead to rely on a laundry list of classic examples." Bobinski, *supra* note 177, at 349 n.209 (explaining how courts determine if relationship is fiduciary).

207. See, e.g., Bobinski, *supra* note 177, at 348-56 (considering how fiduciary principles apply to the physician-patient relationship); Kim Johnston, *Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives*, 35 SAN DIEGO L. REV. 951, 963-66 (1998) (analogizing relationship between physician and patient as fiduciary); Rodwin, *supra* note 205, at 242 ("The idea that physicians are or should be fiduciaries for their patients . . . is a dominant metaphor in medical ethics and law today . . ."). As Mark Hall observes:

The law confers fiduciary status on lawyers, trustees, and agents because of their control over vital decisionmaking and the vulnerability of their clients, and the resulting potential for abuse. Given these incidents of fiduciary status, it is difficult to imagine stronger grounds for imposing fiduciary obligations than those that apply to physicians.

Hall, *supra* note 179, at 760 (summarizing law of fiduciary responsibility).

208. See, e.g., *Hoopes v. Hammargren*, 725 P.2d 238, 242 (Nev. 1986) (emphasizing that since physician-patient relationship is based on trust, physicians are obligated to exercise utmost good faith regarding patients); see also cases cited in Bobinski, *supra* note 177, at 350 n.211 (finding fiduciary relationship exists between physician and patient); Hall, *supra* note 179, at 760 n.245 (finding fiduciary relationship between physician and patient and discussing how fiduciary law affects physicians' conflicts of interest).

209. See *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 483 n.10 (Cal. 1990) ("In some respects the term 'fiduciary' is too broad A physician is not the patient's financial adviser The reason why a physician must disclose possible conflicts is not because he has a duty to protect his patient's financial interests, but because certain personal interests may affect professional judgment.").

gations is less clear. At the most basic level, a fiduciary's duty of loyalty requires her to act for the benefit of another, and she cannot elevate her own interests over those of the beneficiary. This duty may sometimes preclude the fiduciary from engaging in economic or other arrangements that may create a conflict of interest between the fiduciary and the beneficiary of the relationship, but in some instances the risks posed by such arrangements may be mitigated by the fiduciary's disclosure of and the beneficiary's consent to the arrangement.²¹⁰

Although a patient's claim of biased medical decisions will not typically involve a financial conflict of interest, the patient can assert that the physician breached his fiduciary obligation of undivided loyalty to the patient. Specifically, the patient could argue that, by allowing a clinically irrelevant characteristic to influence his choice of treatment, the physician failed to act solely in the patient's best interest. This argument carries the most force when a physician consciously allows a known animus or passion against a particular group to affect his clinical decisions for a member of that group. An example of this is a physician whose homophobia leads him to provide inferior treatment for gay patients. In that circumstance, the physician is consciously elevating his own psychic or emotional interests in acting on his animus over his obligation to advance the patient's best interests. Nevertheless, one could argue—in light of the law's imposition of the “highest standard of conduct” on fiduciaries—that even cases involving unconscious bias present a violation of a physician's fiduciary duties to his patients. Given physicians' high level of expertise and the substantial deference that many patients accord to physicians' recommendations, it seems plausible that physicians' fiduciary obligations should include an obligation to “self police” their decision-making processes for any illegitimate influence. Certainly, the patient, who typically does not have the physician's specialized knowledge and training and whose very need for medical treatment creates vulnerability, is in no position to effectively monitor the physician's thought processes.

But even if we understand a physician's fiduciary duties as including an obligation to engage in self-reflective assessment of his own clinical decisions in order to identify and screen out any bias, does a patient who can prove that her physician violated this duty have any legal recourse? Commentators have noted that the courts' willing characterizations of physicians as fiduciaries have not been matched by an enthusiasm for holding physicians legally accountable.²¹¹ A few courts have given teeth to physi-

210. See Hall, *supra* note 179, at 762-64 (discussing “consentable conflicts”).

211. As Marc Rodwin notes, “In medicine there is a gap between the fiduciary ideal and practice [F]iduciary law principles have been applied to physicians only for very limited purposes Courts and legislatures have not developed comprehensive fiduciary obligations for physicians and do not consistently hold them accountable as such.” Rodwin, *supra* note 205, at 247-48 (suggesting ways fiduciary law principles have been applied to physicians); *cf.* Pryzbowski v. United States Healthcare, Inc., 245 F.3d 266, 281-82 (3d Cir. 2001) (finding that physician

cians' fiduciary obligations, but many of these cases have involved physician dishonesty or abuse of power, arguably separate from the physician's actual treatment or diagnosis of the patient.²¹² By contrast, several courts have refused to allow a separate cause of action for breach of fiduciary duty based on a physician's treatment of a patient.

In *Neade v. Portes*²¹³ a widow sued the physician of her late husband for repeatedly failing to order an angiogram that would have revealed her husband's coronary artery blockage. The plaintiff alleged both that Dr. Portes acted in a medically negligent manner in failing to authorize the angiogram and that he breached his fiduciary duty to the patient by so failing and refusing to disclose to the patient financial incentives that created a financial conflict of interest between him and the patient.²¹⁴ While acknowledging that Illinois courts had recognized the physician-patient relationship as fiduciary in nature, the Illinois Supreme Court refused to recognize a separate cause of action for breach of fiduciary duty on the facts of the case. The court reasoned that both the fiduciary duty action and the malpractice action alleged the same operative facts and the same injury. It concluded that, because the negligence claim of the plaintiff sufficiently addressed the alleged wrongdoing, the fiduciary duty claim would be duplicative.²¹⁵ The court also noted that courts in other jurisdictions similarly refused to recognize fiduciary duty claims against a physician when the essential allegations were of medical negligence.²¹⁶

What is the importance of the court's reasoning in *Neade* for a plaintiff who pursues a breach of fiduciary duty claim against her physician

has no legal duty to advocate on behalf of patient for HMO timely approval of benefits, notwithstanding patient's reference to medical ethics codes).

212. See, e.g., *Nardone v. Reynolds*, 538 F.2d 1131, 1136 (5th Cir. 1976) (allowing tolling of statute of limitations when physician breached fiduciary duty by fraudulently concealing patient injuries); *Koppes v. Pearson*, 384 N.W.2d 381, 386 (Iowa 1986) (same); cf. *Hoopes*, 725 P.2d at 242-43 (allowing patient to include in medical malpractice action claim of exploitation of physician-patient relationship).

213. 739 N.E.2d 496 (Ill. 2000).

214. See *id.* at 499. Specifically, Dr. Portes' compensation by an HMO with which he contracted depended in part on the volume of his medical groups' referrals of patients to specialists or for tests outside the group. See *id.*

215. See *id.* at 502-03 (examining similarities between medical malpractice claim and breach of fiduciary duty claim). The question of the appropriate interaction of fiduciary breach actions and professional negligence actions has also arisen in the attorney-client context. See Caroline Forell, *Oregon's "Hands-Off" Rule: Ethical and Liability Issues Presented by Attorney-Client Sexual Contact*, 29 WILLAMETTE L. REV. 711, 731-60 (1993) (explaining role of breach of fiduciary duty and negligence in attorney-client relationship); Melissa A. Thomas, *When is an Attorney's Breach of Fiduciary Duty in Missouri not Legal Malpractice?*, 63 MO. L. REV. 595, 596 (1998) (analyzing holding of *Klemme v. Best*, 941 S.W.2d 493 (Mo. 1997), and its impact on attorney's breach of fiduciary duty in Missouri).

216. See *Neade*, 739 N.E.2d at 501 (citing *Hales v. Pittman*, 576 P.2d 493, 497 (Ariz. 1978); *D.A.B. v. Brown*, 570 N.W.2d 168, 171 (Minn. Ct. App. 1997); *Garcia v. Coffman*, 946 P.2d 216, 223 (N.M. 1997); *Awai v. Kotin*, 872 P.2d 1332, 1337 (Colo. Ct. App. 1993); *Spoor v. Serota*, 852 P.2d 1292, 1294-95 (Colo. Ct. App. 1992)).

based on an allegedly biased medical decision? If the plaintiff pursuing a fiduciary breach action received treatment or disclosure that fell below the applicable standard of care, a court hearing the claim may conclude that the plaintiff's suit impermissibly recast a malpractice cause of action, perhaps to evade a shorter statute of limitations or avoid legislatively imposed procedural hurdles to medical malpractice claims.²¹⁷ As discussed above,²¹⁸ however, in many cases the victim of a biased medical decision may have received treatment that fits comfortably within the range of accepted medical options. That plaintiff complains not simply of *substandard* treatment (i.e., treatment that falls below the standard of care), but of *suboptimal* treatment (i.e., treatment that was not chosen solely to advance the patient's best medical interests). Moreover, the plaintiff also complains of dignitary harm caused by the violation of trust that occurs when a physician's personal bias infects his clinical judgment in making decisions for the patient. These harms, which flow directly from the physician's violation of the patient's trust, are arguably distinguishable from and independent of the harms complained of in a medical malpractice action.

In addition, allowing a physician's personal bias against a clinically irrelevant characteristic of the patient to affect the physician's judgment seems more ethically questionable and less amenable to amelioration than the financial conflicts of interest at issue in *Neade*. Although some would argue that a breach of fiduciary obligation inheres in a physician's mere agreement to be compensated in a way that gives him incentives to provide patients with less treatment, others could point out that cost control is an imperative in contemporary health care and that financial incentives for physicians may be an acceptable mechanism for encouraging cost-conscious medical practice.²¹⁹ From this viewpoint, a financial conflict of interest is a "consentable" conflict,²²⁰ and the doctor may satisfy his obligation by disclosing the existence of any financial incentives to his patients so that they can better assess their medical options.²²¹ Moreover,

217. Cf. *D.A.B.*, 570 N.W.2d at 171 ("We decline to create a new cause of action simply to permit the putative class to avoid showing injury or to circumvent the legislatively mandated statute of limitations.")

218. For a discussion of the difficulty in showing that biased treatment decisions deviated from the standard of care, see *supra* notes 188-90 and accompanying text.

219. Cf. Peter D. Jacobson & Michael T. Cahill, *Applying Fiduciary Responsibilities in the Managed Care Context*, 26 AM. J.L. & MED. 155, 156-57 (2000) (proposing "process, based on fiduciary duty principles, for resolving potential conflicts of interest arising in managed care and for addressing the mutual antagonism between physicians and attorneys").

220. Many conflicts of interest in legal representation may be cured by the client's informed consent. See, e.g., MODEL RULES OF PROF'L CONDUCT R. 1.7(a) (1987) (allowing lawyer to represent client when representation of that client would be directly adverse to another client as long as lawyer reasonably believes that representing client will not adversely affect relationship to other client and "each client consents after consultation").

221. For example, the plaintiff in *Neade* alleged that if she had known of the compensation scheme for Dr. Portes that she would have sought a second opinion

third parties external to the relationship may have the ability (and perhaps the obligation) to inform the patient of incentives.²²²

Applying parallel reasoning to an alleged fiduciary breach in the form of a biased medical decision illuminates the critical distinctions between complaints of financial conflicts of interest and complaints of physician bias. Do we contemplate a conversation in which a physician informs a patient with a disability that the physician is biased against disabled persons and that he frankly does not think their lives are worth as much as those of “normal” people? Or perhaps a conversation in which a doctor tells an African-American patient that he is biased against African Americans because, based on his personal experience, he doesn’t think they are likely to comply with prescribed treatment regimens?

To my mind, these conversations are neither probable nor desirable responses to the problem of physician bias. Are physicians, if they are aware of their own biases, likely to be willing to disclose them to their patients? Who, but the physician, would be in a position to be able to disclose such biases? And even if physicians did disclose their biases, would that legitimate the influence of those biases on their medical decisions? My response (with which I hope that at least some would agree) would be that bias, even if disclosed, remains problematic because it may serve to interfere with a patient’s receipt of optimal medical care without advancing any legitimate, countervailing interest. We may accept financial conflicts of interests as consentable conflicts whose existence do not inevitably breach the physician’s fiduciary obligations because we recognize they may advance the social goal of health care cost containment. But what social goal is advanced by permitting physicians’ personal biases to infect their medical judgment?

Of course, even if a case can be made that the Illinois court’s reasoning in *Neade* should not apply to claims alleging that the operation of physician bias constituted a breach of fiduciary duty, a big question still looms: What can a plaintiff recover if she successfully persuades the trier of fact that bias affected her physician’s choice of treatment for her? As discussed above, sometimes a plaintiff could claim that bias influenced her doctor to prescribe a treatment other than the one most likely to improve her health. Even if the treatment prescribed fell within the standard of care, the plaintiff could still argue that it was suboptimal and that she suffered injury as a result. If the plaintiff incurred physical injury and she can show

from a physician from a different medical group regarding the advisability of an angiogram. See *Neade*, 739 N.E.2d at 499 (Ill. 2000).

222. The court in *Neade* bolstered its conclusion that a physician’s failure to disclose incentives would not give rise to a fiduciary duty action by emphasizing that the Illinois legislature had already passed a law requiring HMOs to disclose incentive schemes to enrollees. See *id.* at 503-04 (“The Managed Care Act, effective on January 1, 2000, requires that managed care organizations disclose physician incentive plans to patients. Thus, the legislature has chosen to put the burden of disclosing any financial incentive plans on the HMO, rather than on the physician.”).

that the optimal treatment would have allowed her to avoid the injury, she can argue that the harm suffered flowed directly from the operation of bias, which was in breach of the defendant's fiduciary duty. In this case, the plaintiff could highlight that, because no medical malpractice action lies against the physician in this case (because he complied with the standard of care), the fiduciary breach action will not duplicate a negligence action. Of course, courts may be disinclined to impose liability on a doctor who has satisfied the standard of care; the plaintiff's task would be to convince the court that the breach of fiduciary duty is a wrong independent of compliance with the standard of care.²²³

By contrast, if the plaintiff claims that bias influenced her physician's choice of treatment, but she cannot show that the biased treatment caused any physical injury, her task is even tougher. The plaintiff must convince the court of the appropriateness of recovering damages for a purely dignitary harm—the harm to her dignity as a person, caused by her physician's betrayal of her trust. The defendant doctor would doubtless argue that damages should be recoverable only on a showing of actual physical harm, as is required in a malpractice action.²²⁴ The plaintiff can point out, however, that a court may allow the recovery of damages for dignitary harms in informed consent cases because the failure of informed consent deprives the patient of self-determination and may cause mental distress.²²⁵ Similarly, the fiduciary breach that occurs when personal bias influences a physician's treatment choice may well affront the patient's sense of personal dignity, damage his self image and affect his ability to trust physicians in the future.²²⁶ These types of harms may be compensated by damages if

223. Cf. *id.* at 507 (Harrison, C.J., dissenting) (noting that physician's failure to disclose financial incentives "constitute[d] an independent wrong").

224. See Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 322 (1999) (noting that most negligence actions "focus on physical injury as a conclusive manifestation of less tangible wrongs").

225. See *Lugenbuhl v. Dowling*, 701 So. 2d 447, 455-56 (La. 1997) (reasoning, in informed consent action, that "the injury was to plaintiff's personal dignity and right of privacy, an injury for which an award of damages generally is considered appropriate"); see also Krause, *supra* note 224, at 366-67 (arguing that in informed consent case, "where no physical injury has occurred, only a cause of action protecting a 'dignitary' or 'process' right will permit recovery; and without recovery, there can be no vindication of the patient's claim"); Alan Meisel, *A "Dignitary Tort" as a Bridge between the Idea of Informed Consent and the Law of Informed Consent*, 16 J.L. MED. & HEALTHCARE 210, 212-13 (1988) (suggesting that courts are recognizing cause of action for intentional infliction of emotional distress and negligent infliction of emotional distress for purely dignitary harm); Marjorie M. Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 276-92 (1985) (advocating for availability of recovery for dignitary harms when patient has been deprived of his right of choice in medical decision making).

226. These harms may be particularly great if the physician's bias was racial in nature, for the patient's awareness of the operation of racial bias may serve to reinforce the pre-existing, historically based, lack of trust that many African Americans feel for the health care system. See *supra* notes 95-97 and accompanying text (discussing historically based distrust); cf. Robert C. Post, *Racist Speech, Democracy*

they accompany a so-called “dignitary tort.”²²⁷ Admittedly, the action for a physician’s breach of fiduciary duty is not currently a well-established dignitary tort.²²⁸ Given the recognition that damages for dignitary harm may sometimes be recovered in informed consent cases, however, arguing for the availability of such damages in a physician fiduciary breach claim is not too great a stretch.²²⁹

In conclusion, unless a patient-plaintiff can show that bias caused his physician to prescribe a treatment inconsistent with the professional standard of care, the plaintiff may best voice his aggrievement in an action alleging that biased decision making breached the physician’s fiduciary duty to the plaintiff. Even if the physician did not negligently treat the patient and caused the patient no physical harm, the patient who learns of his physician’s bias-infected judgment is harmed by the affront to his personal dignity and integrity, and by the impact on the physician-patient relationship that such a breach of trust entails.²³⁰ Although some courts have recognized that physicians who breach their fiduciary duties may be held liable, others have not. Moreover, the cases recognizing the potential for liability often have involved physician conduct that was not integral to the therapeutic relationship between physician and patient. Thus, a patient who sues her doctor for breach of fiduciary duty may have to struggle to convince the court that she is not simply complaining of professional negligence and that she has suffered compensable harm beyond that associated with any physical injury. Ultimately, existing law provides the raw materials for such a claim, but it remains far from clear whether courts would stretch the existing boundaries of physician liability to encompass this cause of action.²³¹

and the First Amendment, 32 WM. & MARY L. REV. 267, 273 (1991) (examining comparison between racist speech and “forms of communication that are regulated by the dignitary torts of defamation, invasion of privacy, and intentional infliction of emotional distress”).

227. DAN B. DOBBS, *LAW OF REMEDIES* § 7.1, at 259 (2d ed. 1993) (defining dignitary harm where there may be “economic or physical loss . . . the primary or usual concern is not economic at all, but vindication of an intangible right”).

228. *See id.* § 7.3(1), at 302-03 (listing assault, battery, false imprisonment, invasion of privacy, alienation of affections, malicious prosecution and intentional interference with voting and other electoral rights as common law tort actions in which damages for dignitary harms may be recovered).

229. *Cf.* William H. Pedrick, *Arizona Tort Law and Dignified Death*, 22 ARIZ. ST. L.J. 63, 78-79 (1990) (arguing for availability of damages for dignitary harm, even in absence of physical injury, in cases in which health care provider subjects patient to life-sustaining procedures despite patient’s instructions to contrary).

230. *Cf.* Hall, *supra* note 179, at 764 (“If patients were not able to trust their doctors, their anxieties and feelings of vulnerability from exposing the innermost aspects of mind and body either would deter their seeking treatment, would hamper the therapeutic effect of treatment, or would violate a fundamental sense of safety and integrity.”).

231. *Cf.* Krause, *supra* note 224, at 367 (questioning whether tort law would allow recovery for purely dignitary harms in informed consent actions in light of law’s “hostil[ity] to the award of damages for intangible injuries”).

D. *General Barriers to Recovery for Physician Violation of Professional Duties*1. *Challenges of Proving the Operation of Bias*

Regardless of the precise framing of the claim, a plaintiff seeking redress specifically for the operation of bias in clinical decision making will have to prove that bias in fact infected her physician's decision regarding her diagnosis or treatment.²³² Doing so will prove a challenge in most cases—at times an insuperable one. Trying to prove the operation of bias in a suit against a doctor for violating professional duties will present difficulties similar to those a plaintiff suing a doctor for violating a civil rights statute faces in trying to prove intentional discrimination, which will be discussed in Part V.B.2. below.

That said, proving the existence of a physician's bias may be relatively straightforward in some cases. A patient can sometimes point to evidence of a physician's statements to the patient, to the patient's family, to nurses or to the physician's colleagues as demonstrating that the physician entertained one or more stereotypes associated with a non-medical characteristic of the patient. Patients who enjoy no, or only very limited, protection under civil rights laws (for example, gays and lesbians or obese persons), may be more likely to obtain such proof because bias against some unprotected groups remains more socially acceptable (at least in some circles) and the statements may be perceived as less legally risky. The patient can scrutinize not only the physician's statements, but also his actions unrelated to his clinical treatment of the patient, as a basis for inferring that the physician is biased against a group to which the plaintiff belongs.

But what if direct evidence suggesting bias is limited or nonexistent? In that case, the plaintiff can still seek to provide circumstantial evidence of bias by demonstrating that the physician has a pattern of treating patients with a certain characteristic differently from similarly situated patients without that characteristic. For example, a physician may have a pattern of ordering heart bypass surgery for male patients, but not for female patients. From evidence of a pattern of treatment disparities between the physician's male patients and female patients, the plaintiff can argue that the trier of fact should infer bias on the physician's part and find that bias influenced the physician's judgment in the plaintiff's case.

Although the argument for inferring the existence of bias from a pattern of differential treatment is fairly straightforward, obtaining evidence of treatment patterns may prove quite difficult. The medical records of persons who are not parties to litigation fall within the scope of the physi-

232. Of course, the patient first has to become aware, or at least suspicious, of the operation of bias in her doctor's judgments. Because patients typically defer to their physician's judgments and are not equipped to scrutinize the physician's decision-making processes, it seems safe to assume that many, if not most, cases in which physician bias does operate will evade the patient's awareness and will not produce any claim.

cian-patient privilege and generally are not discoverable.²³³ Although state statutes and case law shape its precise contours, the privilege is commonly described as having a dual purpose: “to promote candid and complete communication between doctor and patient in furtherance of competent medical care and to maintain privacy by preventing the disclosure of highly personal information.”²³⁴ Thus, a plaintiff seeking to discover the records of other patients treated by the defendant physician in hopes of identifying a pattern of differential treatment will almost certainly be met with an objection on the grounds of the privilege.

In many jurisdictions, however, the physician-patient privilege is not an insurmountable barrier to obtaining the medical records of non-parties. Courts in a number of jurisdictions have found that allowing discovery of non-party records does not violate the privilege if information identifying those non-parties is redacted.²³⁵ Some courts have allowed discovery based simply on a deletion of identifying information from the records;²³⁶ others have demanded more stringent safeguards for preserving non-party privacy and confidentiality.²³⁷ Regardless of the precise protective measures required, the courts’ rationale in allowing discovery is that disconnecting the information in the records from the identity of any particular patient protects the policies underlying the privilege, while still allowing for the discovery of relevant evidence.²³⁸ Notwithstanding this

233. See generally Scott R. White, Comment, *Discovery of Non-parties’ Medical Records in the Face of the Physician-Patient Privilege*, 36 CAL. W. L. REV. 523, 532 (2000) (highlighting medical malpractice and products liability cases where plaintiffs have made failed attempts at obtaining medical records of non-parties); Audrey W. Collins, Annotation, *Discovery, in Medical Malpractice Action, of Names and Medical Records of other Patients to whom Defendant has Given Treatment Similar to That Allegedly Injuring Plaintiff*, 66 A.L.R. 5th 591, 592-609 (1999) (providing current case law on discovery of non-party medical records).

234. *In re Rezulin Prods. Liab. Litig.*, 178 F. Supp. 2d 412, 416 (S.D.N.Y. 2001) (holding that redaction of identifying information from medical records did not infringe upon physician-patient privilege).

235. See, e.g., *id.* at 416 (S.D.N.Y. 2001) (predicting approach of Texas Supreme Court); *Amente v. Newman*, 653 So. 2d 1030, 1033 (Fla. 1995) (acknowledging that patient’s right to privacy and confidentiality of medical records are protected by redacting identifying information); *Terre Haute Reg’l Hosp., Inc. v. Trueblood*, 600 N.E.2d 1358, 1362 (Ind. 1992) (noting that redaction and confidential protective orders “adequately safeguarded the privacy of non-party patients and preserve[d] the spirit of the physician-patient privilege”).

236. See, e.g., *Amente*, 653 So. 2d at 1030 (requiring redaction of all identifying information).

237. See, e.g., *In re Rezulin*, 178 F. Supp. 2d at 417 (requiring redaction of identifying information and confidential treatment of the redacted records); *Bennett v. Fieser*, 152 F.R.D. 641, 643 (D. Kan. 1994) (requiring redaction of identifying information and agreement by parties and counsel not to attempt to learn patient’s identity or to contact patient).

238. See *In re Rezulin*, 178 F. Supp. 2d at 415 (“Once the information cannot be connected with the patient, the risk of embarrassment that might lead a patient to withhold information from a physician and thus interfere with proper treatment, as well as the risk of any invasion of personal privacy, is eliminated.”).

willingness of many courts to allow the discovery of redacted non-party medical records, some courts maintain a strong version of the physician-patient privilege that blocks all discovery of non-party records.²³⁹ Thus, in those states, plaintiffs who have no direct evidence of physician bias may be barred from discovering evidence capable of showing a pattern of disparate treatment from which bias might be inferred. Still, in most states, if the plaintiff can articulate the relevance of the defendant physician's treatment of his other patients to the plaintiff's attempt to prove bias, seeks the redaction of all identifying information from the non-party records²⁴⁰ and is willing to agree to any further protective measures required by the court, the plaintiff stands a good chance of obtaining discovery of the medical records of other similarly situated patients of the defendant physician.

Of course, even if a plaintiff discovers the medical records of the defendant's other patients similarly situated to the plaintiff, and those records do in fact demonstrate a pattern of differential treatment from which a jury could infer the existence of bias, the plaintiff still must prove that the bias operated in her case and prejudiced her physician's clinical judgment. The fact that a physician holds stereotyped views about a particular group, and consequently tends to treat patients in that group differently from his other patients, does not mean that the physician's bias operates without exception every time he treats a group member.²⁴¹ Thus, it can be tricky to assess whether bias played a role in the defendant's judgment regarding the *plaintiff's* treatment. Even if the physician's

239. See, e.g., *D.H. v. Chi. Hous. Auth.*, 746 N.E.2d 274, 277 (Ill. App. 2001) (finding that deletion of names is not sufficient protection); *In re Columbia Valley Reg'l Med. Ctr.*, 41 S.W.3d 797, 800 (Tex. App. 2001) (holding that redaction of identifying information did not defeat privilege). In addition, even in states where redacted records may be discoverable, the plaintiff still has to show that the information regarding the treatment of other patients is relevant to a pending claim or defense. See *Pusateri v. Fernandez*, 707 So. 2d 892, 893 (Fla. Dist. Ct. App. 1998) (denying discovery request where information requested was not relevant to any pending claim or defense).

240. Aside from defeating the state-law privilege, the redaction of all identifying information is also necessary to keep the patient records from being subject to federal privacy regulations under the Health Insurance Portability and Accountability Act of 1996. See Pub. L. No. 104-91, 110 Stat. 1936 (1996). These regulations create a complex system of privacy protection for health information, but they apply only to personally identifiable information. See *id.* The regulations provide that health information can be made nonidentifiable by the deletion of specific identifying features. See 45 C.F.R. § 164.514 (2001); see also generally Lawrence O. Gostin, *National Health Information Privacy: Regulations Under the Health Insurance Portability and Accountability Act*, 285 JAMA 3015 (2001) (explaining patients' health information privacy rights under Health Insurance Portability and Accountability Act).

241. Cf. Martha Chamallas, *Deepening the Legal Understanding of Bias: On Devaluation and Biased Prototypes*, 74 S. CAL. L. REV. 747, 774 (2001) ("Nor will devaluation operate automatically in every potential case, a fact that sometimes makes it difficult to determine whether the effects of devaluation are felt in a given instance.").

recommended treatment for the plaintiff fits with the pattern of differential treatment, the physician probably will offer a plausible, unbiased medical reason for the choice or will point to the patient's preference as supporting his choice. Accordingly, the plaintiff will have to convince the jury that bias, and not one of these neutral reasons, explains the physician's choice.²⁴²

2. *Challenges of Proving Causation and Damages*

While the preceding discussion regarding the recoverability of damages for dignitary injuries highlights the particular problem confronting a plaintiff who alleges biased medical decision making, but who has suffered no physical injury, even a plaintiff who suffers specific physical harm after receiving medical treatment is likely to have a hard time proving that physician bias caused that harm. Proving that—but for the operation of bias—the plaintiff would not have suffered the harm effectively requires the plaintiff to prove that the intervention that an unbiased physician would have chosen would have led to a superior outcome for the plaintiff.

Of course, if bias in a particular case caused the physician to order treatment that clearly fell outside the standard of care and the patient's condition is one that is typically amenable to effective treatment, the plaintiff-patient may be able to prove causation and resulting damages fairly easily. But if the biased physician's chosen treatment is within the professional standard of care, it becomes more difficult to prove that an unbiased physician more likely than not would have chosen a different treatment. An exception to this general statement might occur when a new technology or treatment is recognized within the medical community as being superior, but has not yet become widely disseminated and thus has not yet effectively preempted other treatments from the standard of care.²⁴³ In that case, a physician who is aware of and has access to the superior treatment but nonetheless, as a result of bias, orders a less effective treatment for a particular patient might be found to have caused the resulting injury, notwithstanding the fact that the treatment ordered complied with the customary standard of care.²⁴⁴ As a result, a court willing to

242. Thus, it appears that the plaintiff's task in a suit alleging that the operation of bias breached some professional medical duty will resemble the application of the *McDonnell Douglas* burden-shifting framework applicable to claims of disparate treatment in civil rights actions. See *infra* Part V.B.

243. An example of such a technology might be tPA therapy for ischemic stroke. This therapy was approved by the FDA only in 1996, but is recommended by published consensus guidelines as an effective therapy when it can be initiated within 3 hours of symptoms beginning. See Johnston et al., *supra* note 77, at 1062. As of 2001, however, tPA was used in "only a small portion of patients with ischemic strokes," and thus presumably was not the exclusive intervention that fell within the customary standard of care for ischemic strokes. See *id.*

244. This analysis, of course, resembles an argument for legislative or judicial adoption of a "reasonable physician" standard of care to replace the customary standard, for it asks "What should this physician have done?," rather than "What do physicians customarily do?" See Phillip G. Peters, Jr., *The Quiet Demise of Deference*

recognize a cause of action based on the operation of bias independent of any deviation from the standard of care might allow for a recovery.

A challenge remains in proving damages where none of the diagnostic and treatment choices available to a physician is certain to be effective. In that case, the plaintiff may be unable to prove that *any* intervention would have prevented the ultimate harm she suffered. In other words, the defendant would argue, the cause of the harm was lung cancer, heart disease or stroke, not the physician's treatment choice. In cases involving conditions for which no generally effective treatment exists, courts that accept the "loss of chance" doctrine may nonetheless allow some recovery if the physician's action caused the patient to suffer a decreased opportunity for cure or survival.²⁴⁵ For example, if surgical removal of a particular type of cancerous tumor combined with chemotherapy leads to a statistical one-year survival rate of forty percent, but aggressive chemotherapy alone produces only a twenty-five percent survival rate, the estate of a patient whose physician orders only chemotherapy cannot argue that she more likely than not would have lived had she received the surgery. The estate can argue, however, that her physician's choice deprived her of an increased chance of survival. Not all jurisdictions, however, have adopted the loss of a chance doctrine,²⁴⁶ and even those that have may not allow a living plaintiff to recover for a claimed decrease in her odds of continued survival.²⁴⁷

Concededly, these challenges to proving causation and damages are not unique to a plaintiff who seeks to recover from a physician for harm associated with a biased medical decision; they are instead problems commonly faced by medical malpractice plaintiffs. It seems plausible to speculate, however, that the novel nature of the plaintiff's claim of biased medical treatment and the difficulty in proving the existence and opera-

to Custom: Malpractice Law at the Millennium, 57 WASH. & LEE L. REV. 163, 168 (2000) (discussing shift in number of states applying "reasonable physician" standard).

245. See, e.g., *Falcon v. Mem. Hosp.*, 462 N.W.2d 44, 52 (Mich. 1990) (recognizing loss of chance where doctor failed to insert intravenous line when patient had 37.5% chance of survival); *Wollen v. DePaul Health Ctr.*, 828 S.W.2d 681, 682-85 (Mo. 1992) (allowing cause of action for lost chance of recovery where patient would have had 30% chance of survival and cure if doctor had performed appropriate tests); *Herskovits v. Group Health Coop.*, 664 P.2d 474, 476-77 (Wash. 1983) (awarding damages where doctor's failure to timely diagnose lung cancer caused 14% reduction in patient's chance for survival); see generally Margaret T. Mangan, Comment, *The Loss of a Chance Doctrine: A Small Price to Pay for Human Life*, 42 S.D. L. REV. 279, 290-92 (1997) (listing jurisdictions that recognize loss of chance doctrine).

246. See Mangan, *supra* note 245, at 299 (reporting that majority of jurisdictions that had addressed loss of chance doctrine had adopted it, but that many courts had either flatly rejected doctrine or continued to use traditional causation principles).

247. See *Wickens v. Oakwood Healthcare Sys.*, 631 N.W.2d 686, 690-91 (Mich. 2001) (suggesting plaintiff can only recover for present injury not potential future injury).

tion of bias in medical decisions may influence the rigor with which a court applies causation and damages limitations. Thus, proving that physical injury resulted from the operation of bias in clinical judgment will typically be an uphill battle. For the plaintiff who has suffered no physical harm and seeks to recover solely for dignitary injuries, the task, discussed above in Part IV.C., is to persuade the courts to extend recovery for dignitary harm to this setting. In either case, the likelihood of recovering damages substantial enough to provide a financial incentive for suit seems quite small in most cases. As a practical matter, these bleak prospects of success seem unlikely to motivate many patients who believe that their physician's medical judgment was infected by bias to bring suit based on some theory of the physician's violation of professional duties.

V. PHYSICIAN LIABILITY FOR CIVIL RIGHTS VIOLATIONS

Given the likely difficulties in succeeding on a claim alleging that a biased decision violated a doctor's professional obligations to an individual patient, perhaps a theory of recovery that adopts a broader view would be more promising. If we approach the influence of bias on medical decision making as a problem of a physician treating similarly situated patients differently, then we can see that the bias produces discriminatory medical treatment decisions. Once we frame the problem as discrimination, then the application of civil rights laws to instances of that discrimination seems a natural response, at least if the characteristic prompting the discrimination is one that receives protection under anti-discrimination laws. This Part will begin by identifying the variety of federal statutes that patients aggrieved by biased medical judgments might invoke in seeking a civil rights remedy. After laying out this arsenal of statutory weapons, this Part will then discuss likely barriers to an effective civil rights remedy for instances of biased medical treatment.

A. Which Civil Rights Statutes Apply?

1. Race-biased Decisions: Title VI of the Civil Rights Act of 1964

A patient who believes that her race, color or national origin influenced her physician's choice of her medical treatment may assert that the physician's actions violated Title VI of the 1964 Civil Rights Act. Title VI prohibits any program or activity that receives federal funding from discriminating based on an individual's race, color or national origin.²⁴⁸ In addition, Title VI authorizes federal agencies that extend federal funding to promulgate regulations to effectuate Title VI's nondiscrimination man-

248. Section 601 of the Civil Rights Act provides: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 42 U.S.C. § 2000d (2001).

date.²⁴⁹ Many federal agencies have issued regulations that prohibit federal funding recipients from employing facially neutral policies or practices that have an adverse disproportionate impact on racially or ethnically defined groups.²⁵⁰ The federal Department of Health and Human Services (DHHS), which extends federal funding for health care programs, is among the agencies that have promulgated disparate impact regulations.²⁵¹

Because the federal portion of all health expenditures made nationally is substantial,²⁵² the number of entities in the health care sector that potentially qualify as a “program or activity receiving Federal financial assistance” is huge. The federal government has poured money into the health care sector in the form of payments through the Medicare and Medicaid programs, through hospital construction grants under the Hill-Burton Act, through the funding of graduate medical education and through its support of community health clinics, to name only some of the largest funding programs. Indeed, the newly minted Title VI was used effectively to combat racial segregation in hospitals in the mid 1960s, when the creation of the Medicare program made virtually all hospitals recipients of “federal financial assistance” in the form of Medicare reimbursement for hospital services.²⁵³ Subsequent attempts to use Title VI to address alleged racial or ethnic inequality in the context of health care, however, have produced more mixed results. Although black patients

249. See 42 U.S.C. § 2000d-1 (2001) (empowering federal departments and agencies to issue rules, regulations or orders with proposed effect of stopping discrimination).

250. See Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn't be Easy*, 58 *FORDHAM L. REV.* 939, 948-55 (1990) (“Disproportionate adverse impact outlaws practices that are facially race neutral but that fall more harshly on minorities and that cannot be justified.”). Title VI regulations for a number of federal agencies were originally crafted by a task force made up of representatives from the White House, the Civil Rights Commission, the Justice Department and the Bureau of the Budget. See *id.* at 947. The task force sought to come up with a template for Title VI regulations that would be consistent but flexible. See *id.* In the end, the task force produced twenty-two sets of Title VI regulations for various federal agencies. See *id.* at 943-44.

251. See 45 C.F.R. § 80.3(b)(2) (2001), which provides:

A recipient, . . . may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.

252. See Katherine Levit et al., *Inflation Spurs Health Spending in 2000*, *HEALTH AFFAIRS*, Jan.-Feb. 2002, at 172 (“Health spending totaled \$1.3 trillion in 2000, with spending averaging \$4,637 per person.”). In 2000, out of \$1,299,500,000,000 in national health expenditures, \$411,500,000,000 (or approximately one third) came from the federal government. See *id.* at 176 (Exhibit 4) (reporting national health expenditures and average annual percentage growth between 1970-2000).

253. See DAVID B. SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION* 121-42 (1999) (explaining beginning of Medicare and Title VI enforcement).

have had some success challenging hospitals' and nursing homes' use of admissions policies that have a disparate impact on black patients,²⁵⁴ cases challenging the relocation or closure of hospitals as having a discriminatory impact have not succeeded.²⁵⁵

From the perspective of a patient who believes himself to be the victim of racially biased medical judgment, the threshold question is whether his doctor would be deemed to be "a program or activity receiving Federal financial assistance" such that the doctor would be bound by Title VI in practicing medicine. Although a physician's medical practice might not typically be thought of as a "program or activity," the statutory definition of that phrase makes clear that a sole proprietorship engaged in the business of health care can be a program or activity subject to Title VI.²⁵⁶ Of course, the statute reaches only as far as federal funding flows, but the majority of physicians in the U.S. receive some federal monies in the form of reimbursement for services provided to persons covered under the Medicare and Medicaid programs. Indeed, physicians receiving Medicare and Medicaid reimbursement have been deemed to be recipients of "federal funding assistance" as that phrase is used in the Rehabilitation Act of 1974.²⁵⁷

Shortly following the enactment of Title VI, however, the federal Department of Health, Education and Welfare interpreted the law such that private physicians who received money for treating patients covered under

254. See, e.g., *Linton v. Comm'r of Health and Env't*, 779 F. Supp. 925, 935 (M.D. Tenn. 1990), *aff'd*, 65 F.3d 508 (6th Cir. 1995) (holding limited bed certification policy has disparate impact on racial minorities in Tennessee); *Cook v. Ochsner Found. Hosp.*, 61 F.R.D. 354, 360 (1972) (finding that admission policy to federally aided hospital "clearly discriminates against a very substantial segment of the public").

255. See, e.g., *Bryan v. Koch*, 492 F. Supp. 212, 233-37 (S.D.N.Y. 1980) (holding that closing of hospital was related to legitimate business objectives and did not violate Title VI); *N.A.A.C.P. v. Wilmington Med. Ctr. Inc.*, 491 F. Supp. 290, 318 (D. Del. 1980) (holding no Title VI violation where minority groups alleged relocation of urban hospital to suburban location would make it more difficult to minority group members to utilize hospital). For a discussion of the application of Title VI in health care settings, see generally David Barton Smith, *Addressing Racial Inequities in Health Care: Civil Rights Monitoring and Report Cards*, 23 J. HEALTH POL. POL'Y & L. 75 (1998) (suggesting ways that "report card" approaches to monitoring performance of health care systems could be used to eliminate discriminatory treatment of patients); *Watson*, *supra* note 250, at 966-71 (analyzing Title VI health care cases).

256. See 42 U.S.C. § 2000d-4a(3)(A)(ii) (2001) (§ 606 of Title VI) ("For the purposes of this subchapter, the term "program or activity" . . . mean[s] all of the operations of . . . an entire corporation, partnership, or other private organization, or an entire sole proprietorship . . . which is principally engaged in the business of providing . . . health care . . .").

257. See, e.g., *Lesley v. Chie*, 250 F.3d 47, 53 (1st Cir. 2001) (discussing physicians' receipt of Medicaid funds); *Howe v. Hull*, 874 F. Supp. 779, 789 (N.D. Ohio 1994) (discussing physicians' receipt of Medicare and Medicaid funds); *Aikins v. St. Helena Hosp.*, 843 F. Supp. 1329, 1339 (N.D. Cal. 1994) (same).

Medicare Part B²⁵⁸ would not be deemed recipients of federal financial assistance. The Department's legal grounding for this policy was the language in Title VI excluding any "contract of insurance or guaranty" from the definition of program or activity. Because Medicare Part B originally mimicked the operation of traditional indemnity insurance (whereby the insured suffered a loss and was therefore indemnified), the Department apparently concluded that the insured's (i.e., patient's) payment of insurance proceeds received from Medicare Part B to a treating physician did not constitute federal financial assistance to the physician.²⁵⁹ This "contract of insurance" rationale, however, would not shield from Title VI coverage physicians who, by contrast, receive direct payment of federal funds for providing services under Medicaid, the State Children's Health Insurance Program or another federally funded program.²⁶⁰ The percentage of physicians nationally who provide services to Medicaid recipients, however, is notably smaller than the percentage who treat Medicare beneficiaries.

As David Barton Smith points out, the rationale for placing physicians participating in the Medicare program beyond the reach of Title VI has become "increasingly attenuated with time." Over the past two decades, the Medicare program has taken a number of steps to encourage or require private physicians to accept payment directly from Medicare as payment in full for services rendered to Medicare beneficiaries.²⁶¹ Moreover,

258. See FURROW ET AL., *supra* note 176, at 538 (2000) (explaining how Medicare is administered). Parts A and B of the Medicare program provide coverage for medical care for the majority of Medicare beneficiaries. See *id.* Part A covers inpatient hospital care, skilled nursing care, home health care and hospice services. See *id.* Part B pays for physicians' services and outpatient hospital services, among other services. See *id.* Under Part C, which the Balanced Budget Act of 1997 created, the Medicare program contracts with prepaid managed care plans to cover all basic benefits covered by Parts A and B for Medicare beneficiaries who enroll in those plans. See *id.*

259. See SMITH, *supra* note 253, at 161-63 (describing definition of Part B of Medicare as "private contract of insurance" and not "direct grant of public funds"). Smith views this "contorted, but much desired, legal rationale for exempting physicians participating in the Medicare program from accountability to Title VI" as a product of both the political realities of the time that rendered unrealistic any attempt to enforce Title VI against individual physicians and the administrative complexities of enforcing the statute against the large number of individual physicians participating in Medicare. See *id.* ("As to the political realities at the time of the passage of Medicare, imposing any kind of Title VI requirements on medical practices was inconceivable. Local medical societies, state societies, and the AMA were powerful political forces and reluctant, if not only hostile, participants in the Medicare program.")

260. See Sara Rosenbaum et al., *U.S. Civil Rights Policy and Access to Health Care by Minority Americans: Implications for a Changing Health System*, 57 MED. CARE RESEARCH & REV. 236, 255-56 n.2 (Supp. 1 2000).

261. See SMITH, *supra* note 253, at 163. Payments under Medicare Part B can be made directly to a physician on an assigned basis if the physician agrees to accept Medicare's payment as payment in full for services rendered to a beneficiary. See *id.* ("[M]edicare has required physicians to accept direct payment or assignment from Medicare."). Over the past fifteen years, Congress has enacted

a substantial number of Medicare beneficiaries are now enrolled in managed care plans offering coverage under Medicare Part C; these managed care plans, which receive funds directly from Medicare to provide all Medicare-covered benefits (both Part A and Part B), contract with physicians to render medical services to the Medicare enrollees. Thus, these plans should certainly be seen as recipients of federal funding assistance, and the actions of physicians whom the managed care plans engage to provide medical services arguably should be seen as subject to Title VI's constraints.²⁶² As others have argued: "[T]he evolution to managed care would presumably be profoundly important where the application of Title VI principles to physician practices is concerned. The reach of a monthly enrollment fee consisting of federal funds would appear to bind the network [physicians] to Title VI obligations"²⁶³

Applying Title VI's nondiscrimination mandate to managed care plans that contract to provide health services to Medicare beneficiaries could be particularly significant because Title VI not only constrains the actions of a funding recipient with respect to individuals who are receiving federally funded services from the recipient, but also prohibits the recipient from discriminating in any of its activities.²⁶⁴ In other words, if HMOs

various measures aimed at increasing the percentage of physicians who accept assignment. See FURROW ET AL., *supra* note 176, at 565-67 (noting that since 1984 Congress enacted such methods to regulate physicians while strictly limiting annual increases in fees that physicians who did not agree to accept assignment in Medicare cases could charge).

262. Cf. 45 C.F.R. § 80.3(b) (2001) (listing specific discriminatory actions that recipient subject to Title VI may not engage in "directly or through contractual or other arrangements").

263. Rosenbaum et al., *supra* note 260, at 251; accord SMITH, *supra* note 253, at 163 ("An increasing percentage of Medicare beneficiaries are enrolled in HMOs that receive pooled funds from both Part A and Part B as capitation payments.").

264. See *Grimes v. Superior Home Health Care of Middle Tenn., Inc.*, 929 F. Supp. 1088, 1091-92 (M.D. Tenn. 1996) (allowing cause of action under Title VI using expansive interpretation of "program or activity"). Prior to 1988, the courts had interpreted Title VI's constraints as applying only to the institution's specific programs or activities that received federal funds. See *Consol. Rail Corp. v. Darrone*, 465 U.S. 624, 634-36 (1984) (limiting § 504's ban on discrimination to specific program that receives federal funds). Congress's enactment of the Civil Rights Restoration Act of 1987, Pub. L. No. 100-259, 102 Stat. 28 (1988), however, overturned this program-specific reading of Title VI. The definition of "program or activity" provided by the 1987 Act made clear that all the operations of an institution receiving federal financial assistance would be subject to Title VI. See 42 U.S.C. § 2000d-4a (2001)

("[T]he term 'program or activity' and the term 'program' mean all of the operations of . . . a department, agency, special purpose district, or other instrumentality of a State or of a local government; or the entity of such State or local government that distributes such assistance and each such department or agency to which the assistance is extended . . . ; a college, university, or other postsecondary institution, or a public system of higher education or other school system; an entire corporation, partnership, or other private organization, or an entire sole proprietorship");

providing coverage to Medicare beneficiaries under Part C are deemed to be recipients of federal financial assistance under Title VI, then the obligation of the HMO (and its contractually engaged network physicians) to refrain from discrimination extends not only to its Medicare enrollees, but to all its enrollees.²⁶⁵

Thus, even if the original administrative policy that a physician's receipt of Medicare Part B payments does not trigger Title VI coverage could withstand a contemporary legal challenge, a physician who receives federal financial assistance in the form of Medicaid reimbursement, or who is contractually linked to a managed care plan that provides services for Medicare or Medicaid enrollees, should be seen as subject to the constraints of Title VI. Consequently, a patient who can show that such a physician discriminated based on the patient's race in making a medical treatment decision should have a remedy under Title VI. That remedy could take the form of injunctive relief, if the patient can establish standing by demonstrating a "real or immediate threat that the plaintiff will be wronged again."²⁶⁶ Alternatively, a patient proving intentional discrimination could seek monetary damages under Title VI.²⁶⁷ Of course, as will be explored below,²⁶⁸ the trick in virtually all such cases will be proving that the doctor discriminated based on race. It is worth highlighting here, though, that—if the plaintiff can prove discrimination—Title VI applies and provides an avenue of legal recourse to the victim of a racially biased treatment decision by a physician who receives federal financial assistance. By contrast, racially biased decision making by a physician who receives no federal funding—whether directly or through contractual arrangements—would appear not to trigger civil rights liability.²⁶⁹

Crimes, 929 F. Supp. at 1091-92 (noting that Civil Rights Restoration Act of 1987 overturns program-specific interpretation of *Consolidated Rail*).

265. See Rosenbaum et al., *supra* note 260, at 251 (making point that Title VI obligations would extend to all of managed care organization's product lines). The same reasoning would apply with respect to an HMO that provides coverage under a state Medicaid plan.

266. See *Atakpa v. Perimeter Ob-Gyn Assocs.*, 912 F. Supp. 1566, 1573 (N.D. Ga. 1994) (quoting *City of Los Angeles v. Lyons*, 461 U.S. 95, 111 (1983) (finding that patient had not made allegations sufficient to establish standing)).

267. See *id.* at 1574 (citing *Guardians Ass'n v. Civil Service Comm'n*, 463 U.S. 582 (1983)); cf. *Ferguson v. City of Phoenix*, 931 F. Supp. 688, 697 (D. Ariz. 1996) ("post-*Franklin v. Gwinnett County Pub. Schs.*, 503 U.S. 60 (1992), cases have uniformly held that compensatory damages under Title VI are available, but only for intentional violations of the act").

268. See Part V.B.2. *infra*.

269. For a discussion of how civil rights liability is triggered for a physician under Title VI, see *supra* notes 242-62 and accompanying text. While a patient who alleges bias in a physician's choice of treatment probably has no remedy, a patient who alleges a physician's racially biased refusal to establish a doctor-patient relationship may state a claim under 42 U.S.C. § 1981, which prohibits racial discrimination in contracting even among purely private individuals. Cf. *Harry v. Marchant*, 291 F.3d 767, 775 (11th Cir. 2002) (remanding claim that hospital's refusal to provide medical services to individual was racially discriminatory, violating § 1981) (en banc).

2. *Gender-biased Decisions: Is there an Applicable Statute in the House?*

While Title VI would appear to prohibit racially or ethnically biased clinical decisions by a physician who receives federal financial assistance, it does not prohibit gender-biased decision making. Thus, a patient who believes that her physician's treatment recommendation was influenced by the patient's gender (beyond any legitimate clinical relevance) must look to other civil rights statutes for any available relief. Two statutes prohibiting sex discrimination are Title VII of the Civil Rights Act,²⁷⁰ which prohibits sex discrimination in employment settings, and Title IX of the Civil Rights Act,²⁷¹ which prohibits sex discrimination in educational programs receiving federal funds. Neither of these statutes, however, is likely to provide any remedy to a victim of gender-biased clinical decisions.

a. Title VII's Prohibition on Employment Discrimination

At first blush, Title VII's prohibition on sex discrimination by employers might appear to have no bearing on gender discrimination in the health care context. Title VII, however, prohibits employers from discriminating against women not only in hiring, firing and promotion decisions, but also with respect to the benefits the employer provides, including health benefits.²⁷² Moreover, Title VII applies to forbid both intentional discrimination against women as well as employer policies and practices that are facially neutral, but that have a disparate impact on women.²⁷³ Thus, an employer may be subject to Title VII liability for providing a benefit that, on its face, is available equally to men and women employees, but that is less valuable to women employees. A recent example is the decision in *Erickson v. Bartell Drug Co.*,²⁷⁴ where an employer-provided health plan that excluded coverage of prescription contraceptives violated Title VII because "the exclusion of prescription contraceptives creates a gaping hole in the coverage offered to female employees, leaving a fundamental and immediate health care need uncovered."²⁷⁵

But even if discrimination in the terms of employer-provided health insurance coverage may violate Title VII, it remains difficult to imagine

270. 42 U.S.C. § 2000e-2 (2001).

271. 20 U.S.C. § 1681(a) (2001).

272. See 42 U.S.C. § 2000e-2(a)(1) (2001). It is unlawful for an employer "to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin." See *id.* Health insurance and other health benefits come within the meaning of the phrase "compensation, terms, condition, or privileges of employment." See *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669, 682 (1983) (finding pregnancy limitation in petitioner's amended health plan discriminates against male employees in violation of Title VII).

273. See Sylvia A. Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363, 373-74 (1998) (asserting potential claims under Title VII).

274. 141 F. Supp. 2d 1266 (W.D. Wash. 2001).

275. See *id.* at 1277 (recognizing different medical needs of male and female employees and need to provide equal medical coverage).

how Title VII would ever reach biased medical decision making. Physician bias, when it exists, operates in individual physician-patient encounters and colors a physician's decision making with respect to individual patients. The biases and stereotypes that infect an individual physician's clinical judgments are not easily conceptualized as falling within the "compensation, terms, conditions, or privileges" offered by an employer. Even if an employer self-insures the health care expenses of its employees rather than purchasing a commercial group insurance policy to cover those expenses, the employer's mere reimbursement of employee medical expenses would not seem to transform the medical services that produced those expenses into "compensation, terms, conditions, or privileges of employment." The only situation in which Title VII might arguably provide a remedy for gender-biased medical decision making would be in those rare instances where the employer actually hires physicians to provide health care services to employees. In that case the employer could arguably be held liable under agency theory for the physician's discriminatory treatment of employee patients.²⁷⁶ Thus, Title VII could provide an avenue for legal redress of gender-biased medical treatments decisions only in an extremely limited number of cases.²⁷⁷

b. Title IX's Prohibition on Educational Discrimination

Would, by contrast, Title IX of the Civil Rights Act provide a possible remedy in a broader range of cases? Title IX, best known for bringing schoolgirls onto athletic playing fields, broadly prohibits sex discrimination in "any education program or activity receiving Federal financial assistance."²⁷⁸ Graduate medical education programs—the teaching hospitals in which physician interns and residents complete their postgraduate training under the supervision of teaching physicians—certainly receive their share of federal funding,²⁷⁹ and thus arguably fall within the scope

276. See 42 U.S.C. § 2000e-2 (2001) (expressing definition of "employer" in Title VII as including "any agent" of employer); see also *id.* at § 2000e(b). The courts have interpreted the inclusion of the "any agent" language as providing a basis for holding employers liable, under a theory of respondeat superior, for the discriminatory acts of supervisory personnel. See *McCue v. Kan. Dept. of Human Res.*, 165 F.3d 784, 788 (10th Cir. 1999) ("As a result of this clear statutory instruction, courts have long and consistently held that the scope of liability in Title VII actions is defined by the law of agency.") (dicta); see also Rebecca Hanner White, *Vicarious and Personal Liability for Employment Discrimination*, 30 GA. L. REV. 509, 520 (1996) (asserting that Title VII "define[s] employer to include any agent of the employer"). Of course, this statement does not answer the question whether discriminatory decisions by an employer-hired physician would be treated similarly to discriminatory actions of a supervisor.

277. *Accord* Rothenberg, *supra* note 12, at 1256 ("Because Title VII only applies in the employment context, its legal application to clinical research and other health care may be limited.")

278. 20 U.S.C. § 1681(a) (2001).

279. See Jeffrey E. Shuren, *Financing the Nation's Graduate Medical Education: A Hybrid Approach*, 33 VAL. U. L. REV. 181, 182 (1998) ("Teaching hospitals finance graduate medical education through revenues generated from patient care and

of Title IX's prohibition.²⁸⁰ Thus, a woman who believes that she has received biased medical treatment from an intern, resident or teaching physician participating in a graduate medical education program may argue that the treatment violated Title IX.

Despite the weighty link between the federal purse and teaching hospitals, several problems with this theory of liability leap to mind. First, Title IX's protection from sex discrimination may be limited to students and employees of federally funded education programs.²⁸¹ Accordingly, a patient receiving treatment from a student or employee would not have a cognizable Title IX claim. In addition, courts would likely be unwilling to hold the graduate medical education program vicariously liable for a Title IX violation based on a medical decision by an employee physician. The program itself could be held liable for violating Title IX only if some program official, who had the authority to address the allegedly biased clinical decisions, actually had knowledge of the biased decisions and failed to take any corrective action.²⁸² Thus, because Title IX constrains only the educational program's behavior, individual employees of the program are not proper defendants in a Title IX action.²⁸³ Given these limitations, the chances of success for a patient who received gender-biased medical treatment at a teaching hospital would be miniscule.

3. *Disability-biased Decisions*

Contrasting with the dearth of federal civil rights statutes potentially applicable to gender-biased medical decisions, two federal statutes—Sec-

governmental subsidies. The federal government, through Medicare reimbursement and payments by the Department of Defense and Veteran Affairs, is the largest single source of funding.”).

280. *But cf.* *Crandell v. New York Coll. of Osteopathic Med.*, 87 F. Supp. 2d 304, 317-22 (S.D.N.Y. 2000) (finding that former medical student could bring Title IX sexual harassment action based on misconduct that occurred during mandatory clinical rotation at private hospital while plaintiff was student, but not for misconduct that occurred during her paid post-graduate internship); *Lipsett v. Rive-Mora*, 669 F. Supp. 1188, 1193 (D.P.R. 1987), *rev'd on other grounds*, 864 F.2d 881 (1st Cir. 1988) (finding that Veterans Administration Hospital was not proper Title IX defendant simply because it permitted medical school's surgery residents to rotate through hospital's surgical wards).

281. *See Lopez v. San Luis Valley, Bd. of Coop. Educ. Servs.*, 977 F. Supp. 1422, 1425 (D. Colo. 1997) (“No court has held that a plaintiff who is neither a potential beneficiary of a federally funded education program nor an employee of such a program can maintain a Title IX action for sex discrimination. Indeed, many courts, in dicta, have limited the range of proper Title IX plaintiffs to students and program employees.”).

282. *See Mercer v. Duke Univ.*, 181 F. Supp. 2d 525, 539-41 (M.D.N.C. 2001) (applying standard articulated in *Gebser v. Lago Vista Independent School District*, 524 U.S. 274 (1998)).

283. *See Smith v. Metro. Sch. Dist. Perry Township*, 128 F.3d 1014, 1021 (7th Cir. 1997), *cert. denied*, 524 U.S. 951 (1998) (holding that neither principal nor assistant can be considered grant recipient under Title IX).

tion 504 of the Rehabilitation Act of 1973 (Section 504)²⁸⁴ and the Americans with Disabilities Act (ADA)²⁸⁵—may apply if a person with a disability alleges that his disability biased his physician’s medical judgment. Both of these statutes prohibit discrimination based on disability, and the later of the two (the ADA) is patterned on the earlier. The two statutes, however, differ in the range of actors subject to their prohibitions and in the remedies available to victims of a statutory violation. This section will briefly outline these differences and then examine an issue common to the application of both Section 504 and the ADA to discriminatory medical decision making: Does disability discrimination law properly reach such decisions?

a. Section 504

Congress patterned the anti-discrimination provision included in the Federal Rehabilitation Act of 1973 after Title VI of the Civil Rights Act of 1964. Accordingly, Section 504’s prohibition on disability discrimination is limited (as is Title VI’s prohibition on racial discrimination) to programs and activities receiving federal financial assistance.²⁸⁶ As noted above in the discussion of Title VI, however, the extent of federal expenditures on health care keep the limiting phrase from being terribly limiting in the health care context. Courts have found a variety of different health care providers, including individual physicians, to be recipients of federal funding subject to Section 504’s constraints.²⁸⁷ Because Section 504 (unlike Title VI) does not exclude “contracts of insurance” from the federally funded programs and activities covered, no barrier would appear to prevent holding physicians receiving Medicare Part B payments accountable

284. 29 U.S.C. § 794 (2001) (codifying section 504 of Rehabilitation Act of 1973).

285. 42 U.S.C. §§ 12101-12213 (2001) (codifying Americans with Disabilities Act).

286. *See* 29 U.S.C. § 794(a) (2001). Section 504 provides:
No otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United State Postal Service.

Id.

287. *See, e.g.*, *Lesley v. Hee Man Chie*, 250 F.3d 47, 53 (1st Cir. 2001) (obstetrician who received Medicaid funds); *Frazier v. Bd. of Trs.*, 765 F.2d 1278, 1289 (5th Cir. 1985), *cert. denied*, 476 U.S. 1142 (1986) (respiratory therapy corporation under contract with hospital); *Zamora-Quezada v. Health Tex. Med. Group*, 34 F. Supp. 2d 433, 440 (W.D. Tex. 1998) (HMO that received Medicare payments); *Dorer v. Quest Diagnostics Inc.*, 20 F. Supp. 2d 898, 900 (D. Md. 1998) (laboratory that received federal funds); *People by Vacco v. Mid Hudson Med. Group, P.C.*, 877 F. Supp. 143, 149-50 (S.D.N.Y. 1995) (medical clinic that received Medicare and Medicaid funds); *Matter of Baby K*, 832 F. Supp. 1022, 1027 (E.D. Va. 1993), *aff’d*, 16 F.3d 590 (4th Cir. 1994), *cert. denied*, 513 U.S. 825 (1994) (hospital that received Medicare and Medicaid funds).

for any discriminatory actions. Notwithstanding this distinction in statutory language, however, DHHS has adopted a “contracts of insurance” exclusion in its regulations under Section 504.²⁸⁸ Thus, a patient who has a disability and who believes that disability bias influenced her physician’s treatment choices can argue that the physician’s decision subjected her to discrimination in violation of Section 504, as long as the physician receives Medicare or Medicaid payments.²⁸⁹ A physician who is accused of violating Section 504 and whose only source of federal funding is Medicare Part B payments may defend on this basis, but the strength of this defense remains unclear. The patient who brings a Section 504 action against her physician can seek either appropriate injunctive relief or compensatory damages for any injury suffered as a result of the discrimination.²⁹⁰

b. Americans with Disabilities Act

When Congress enacted the Americans with Disabilities Act in 1990, it extended Section 504’s existing prohibition against disability discrimination to a far broader range of actors. Congress accomplished this extension by uncoupling the anti-discrimination mandate from the receipt of federal funding and applying it directly to employers, public entities and public accommodations. Of particular interest for this Article’s purpose is the ADA’s prohibition of disability discrimination by public accommodations, for the statute’s illustrative list of public accommodations subject to

288. See 45 C.F.R. § 84.3(h) (2002) (defining what constitutes federal financial assistance). The Department explains its reasoning with respect to Medicare Part B payments as follows: “[W]hether or not Medicare Part B arrangements involve a contract of insurance or guaranty, no Federal financial assistance flows from the Department to the doctor or other practitioner . . . since Medicare Part B—like other social security programs—is basically a program of payments to direct beneficiaries.” See 45 C.F.R. § 84, app. A, definitions.

289. In order to make out a prima facie case of violation of § 504, a plaintiff must prove: “(1) that [he] is a handicapped individual under the Act, (2) that [he] is otherwise qualified for the benefit sought, (3) that he was subjected to discrimination solely by reason of his handicap, and (4) that the program or activity in question receives federal financial assistance.” *Grzan v. Charter Hosp. of N.W. Ind.*, 104 F.3d 116, 116 (7th Cir. 1997).

290. See 29 U.S.C. § 794(a) (2001). The Rehabilitation Act expressly provides that the remedies available under § 504 are the same as the remedies available under Title VI. See *id.* Although the question of availability of compensatory damages under § 504 has not been directly addressed by the Supreme Court, the Court’s holding that compensatory damages are available for violations of Title IX, *Franklin v. Gwinnett County Public Schools*, 503 U.S. 60 (1992), has been cited by lower courts as compelling a similar conclusion in the § 504 setting, at least in cases involving intentional discrimination. See, e.g., *Ali v. City of Clearwater*, 807 F. Supp. 701, 705 (M.D. Fla. 1992), (“In cases of intentional discrimination, damages are not limited to those equitable in nature.”); *Doe v. District of Columbia*, 796 F. Supp. 559, 572-72 (D.D.C. 1992) (“[B]ased on the Supreme Court’s recent decision in *Franklin* compensatory damages are available under the [Rehabilitation] Act.”); *Tanberg v. Weld County Sheriff*, 787 F. Supp. 970, 973 (D. Colo. 1992) (“Compensatory damages are available if Tanberg proves intentional discrimination under the [Rehabilitation] Act.”).

the ADA includes the “professional office of a health care provider.”²⁹¹ As a result, Title III of the ADA prohibits any physician in private practice, who owns or operates his own professional office, from discriminating against a person with a disability regardless of whether the physician receives federal funding in any form.²⁹² Of course, physicians employed by publicly owned and operated hospitals and clinics may also make disability-biased medical decisions. Any behavior of these physicians that is arguably discriminatory would be covered not by Title III of the ADA, but by Title II, which prohibits disability discrimination by public entities.²⁹³

While the ADA prohibits disability discrimination by a broader range of actors than does Section 504, its remedies for a plaintiff suing a physician alleging disability discrimination are more limited. Title III—the portion of the ADA most likely to be implicated in such a suit—provides only for injunctive relief, as opposed to money damages, in a private action.²⁹⁴ Because only injunctive relief is available, a plaintiff suing a physician for violating Title III must satisfy standing requirements. The inability of a plaintiff to show his likelihood of facing future harm from the alleged unlawful conduct has barred the claims of several Title III plaintiffs in the health care context.²⁹⁵ Although a patient with serious or chronic health problems such as heart disease or cancer may assert that he will need continued care and advice from his physician and thus faces a threat of continued discrimination, demonstrating the likelihood of continued

291. 42 U.S.C. § 12181(7)(F) (2001). The only statutory limit on when such private entities will be considered public accommodations is that the operation of the entity must affect commerce. See 42 U.S.C. § 12181(7) (2001).

292. See 42 U.S.C. § 12182(a) (2001) (stating general rule of Title III which is that “[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation”). This statutory section goes on to elucidate the meaning of this general prohibition and to prohibit specifically several forms of discrimination. See generally *id.*

293. See 42 U.S.C. § 12131(1)(B) (2001) (acknowledging that ADA defines “public entity” to include “any department, agency, . . . or instrumentality of a State . . . or local government”).

294. See 42 U.S.C. § 12188(a)(2) (2001) (recognizing appropriate remedy for violation of this section is injunctive relief). The statute also authorizes the Attorney General to file an action if the Attorney General has reasonable cause to believe that a “pattern or practice” of discrimination under Title III exists. See *id.* at § 12188(b)(1)(B)(i) (2001). In such an action, the range of remedies available to a court includes “monetary damages to persons aggrieved when requested by the Attorney General.” 42 U.S.C. §§ 12188(b)(1)(B), (b)(2)(B).

295. See *Bravin v. Mount Sinai Med. Ctr.*, 186 F.R.D. 293, 301 (S.D.N.Y. 1999) (dismissing ADA claim that hospital had failed to provide auxiliary aids to deaf person for lack of standing); *Proctor v. Prince George’s Hosp. Ctr.*, 32 F. Supp. 2d 820, 833 (D. Md. 1998) (same); *Hoepfl v. Barlow*, 906 F. Supp. 317, 323 (E.D. Va. 1995) (finding no standing for plaintiff seeking injunctive relief against physician who allegedly had refused to perform surgery on HIV+ plaintiff); *Aikins v. St. Helena Hosp.*, 843 F. Supp. 1329, 1335 (N.D. Cal. 1994) (dismissing ADA claim that hospital had failed to provide auxiliary aids to deaf person for lack of standing).

discrimination may be difficult. Thus, if the allegedly biased decision making occurs only in a single, isolated incident, the patient may find no relief available under Title III.

If, by contrast, the plaintiff alleges that a physician employed by a public health care facility made a disability-biased medical decision, the ADA's public entity provisions in Title II would supply the appropriate avenue of relief.²⁹⁶ An individual with a disability who believes she has been the victim of discrimination by a public entity can bring a private suit in federal court, and Title II provides that the plaintiff is entitled to the full range of remedies available under Section 504.²⁹⁷ Thus, a plaintiff suing a public entity could seek and recover monetary damages.

The ability to bring an ADA action in federal court to recover money damages from a public entity that is a state agency, however, has been thrown sharply into question by the Supreme Court's decision in *Board of Trustees of the University of Alabama v. Garrett*.²⁹⁸ In *Garrett*, the Court held that the Eleventh Amendment's grant of sovereign immunity barred a suit for money damages by state employees under the employment provisions of Title I of the ADA. Although *Garrett* did not address whether the Eleventh Amendment bars suits against state agencies under Title II of the ADA, at least three circuit courts of appeals have so held.²⁹⁹ Because Eleventh Amendment sovereign immunity does not extend to units of local government,³⁰⁰ by contrast, a Title II action against a county-operated public hospital would not face this barrier.

296. See *Duvall v. County of Kitsap*, 260 F.3d 1124, 1141 (9th Cir. 2001) (applying respondeat superior to hold county vicariously liable for actions of county employees).

297. See 42 U.S.C. § 12133 (2001). For a discussion of § 504 remedies, see *supra* note 284 and accompanying text.

298. 531 U.S. 356 (2001).

299. See *Reickenbacker v. Foster*, 274 F.3d 974, 984 (5th Cir. 2001) (finding that Title II did not represent valid exercise of congressional power); *Thompson v. Colo.*, 258 F.3d 1241, 1255 (10th Cir. 2001) (granting immunity under 11th Amendment); *Alsbrook v. City of Maumelle*, 184 F.3d 999, 1012 (8th Cir. 1999) (en banc) (same); cf. *Popovich v. Cuyahoga County Ct. Com. Pl.*, 276 F.3d 808, 810-11 (6th Cir. 2002) (finding that Congress did not have authority under Section 5 to enforce equal protection component of 14th Amendment by enacting Title II, but finding Section 5 authority to enforce due process component of 14th Amendment in that case); *Garcia v. S.U.N.Y. Health Scis. Ctr. of Brooklyn*, 280 F.3d 98, 111 (2d Cir. 2001) (concluding that individual can sue state in federal court for Title II violation only if plaintiff can show that alleged violation was motivated by ill will or animus based on disability). But see *Wroncy v. Or. Dept. of Transp.*, 9 Fed. Appx. 604, 605 (9th Cir. 2001) (rejecting 11th Amendment immunity challenge to Title II).

300. See *Garrett*, 531 U.S. at 357 (citing *Lincoln County v. Luning*, 133 U.S. 529 (1890)).

c. Does Disability Discrimination Law Reach Medical Treatment Decisions?

The foregoing discussion suggests that federal law prohibiting disability discrimination extends to most physicians in the United States, either because the physician receives federal financial assistance, owns or operates a public accommodation or is the agent of a public entity. While remedial issues may prove problematic, as discussed above, it is clear that physicians cannot legally discriminate against persons with disabilities. Thus, a physician cannot refuse to provide treatment to an individual with a disability without running afoul of these laws.³⁰¹

The more precise question—whose answer is far murkier—is whether legal prohibitions on disability discrimination apply at all to a physician's decisions regarding *what* medical treatment to provide. In other words, while Section 504 and the ADA clearly apply to prevent physicians from denying persons with disabilities access to their offices, it is questionable whether those laws apply to the physician's diagnostic and therapeutic decisions for a disabled patient whom the physician has agreed to treat. Indeed, a line of cases decided under Section 504 concludes that the law cannot properly be applied to allegedly discriminatory clinical decisions.³⁰² The broader question of whether any civil rights laws can appropriately be applied to medical decisions will be addressed below. The question, however, has particular salience with respect to disability discrimination law because in many cases the patient's disability will itself be the impetus for the patient's seeking medical attention. In that case, how can the treatment provided to the patient be meaningfully compared to the treatment provided to another patient without the disability in order to determine whether discrimination occurred? More generally, is a court equipped to assess how and to what extent a physician legitimately can consider a patient's disability in making complex medical treatment choices?³⁰³

Some cases indicate that disability discrimination law simply does not apply to medical treatment decisions and that courts should defer to physi-

301. Cf. *Bragdon v. Abbott*, 524 U.S. 624, 653-55 (1998) (invoking Title III against dentist who refused to fill cavity of patient with HIV infection).

302. See *Toney v. U.S. Healthcare, Inc.*, 838 F. Supp. 201, 204 (E.D. Pa. 1993), *aff'd*, 37 F.3d 1489 (3d Cir. 1994) (holding that "a determination by a physician of when her regular patient's condition warrants an additional office visit is a medical treatment decision not subject to judicial review"); *Grzan v. Charter Hosp. of N.W. Ind.*, 104 F.3d 116, 123 (7th Cir. 1997) (concluding that Section 504 did not apply to medical treatment decisions for psychiatric patients); *U.S. v. Univ. Hosp., State Univ. of N.Y. at Stony Brook*, 729 F.2d 144, 161 (2d Cir. 1984) (same); *Johnson v. Johnson v. Thompson*, 971 F.2d 1487, 1493 (10th Cir. 1992) (concluding that Section 504 did not apply to medical treatment decisions for disabled infants).

303. For a proposed approach to these questions, see Mary A. Crossley, *Of Diagnoses and Discrimination: Discriminatory Nontreatment of Infants with HIV Infection*, 93 COLUM. L. REV. 1581, 1655 (1993) (proposing "medical effects" approach that would allow physicians to consider medical effects of disability, but not mere existence of disability, in making medical decisions).

cians' medical judgments.³⁰⁴ A number of cases decided after the passage of the ADA, however, recognize that disability discrimination law may place some limits on physicians' medical decisions.³⁰⁵ Although these cases suggest that some courts may be willing to entertain a disabled plaintiff's claim that discriminatory medical treatment decisions violate Section 504 or the ADA, other courts may remain reluctant even to consider such a claim.

4. *Age-biased Decisions*

Only a few years after using Title VI as a model for Section 504 of the Federal Rehabilitation Act in 1973, Congress turned again to Title VI as a model with its enactment of the Age Discrimination Act of 1975 (the Act). The purpose of the Act is to prohibit age-based discrimination in federally funded programs, and its basic prohibition largely tracks the statutory language of Title VI and Section 504.³⁰⁶ Thus, many of the points made regarding when physicians may be deemed recipients of federal financial assistance under those statutes apply as well to the Age Discrimination Act.³⁰⁷

304. *See supra* note 302.

305. *See, e.g.,* Lesley v. Hee Man Chie, 250 F.3d 47, 55 (1st Cir. 2001) (concluding that medical decision can violate § 504 if it is shown to be "devoid of any reasonable medical support"); Jairath v. Dyer, 972 F. Supp. 1461, 1470 (N.D. Ga. 1997) ("Use of caution in making medical decisions is to be distinguished from situations in which doctors blatantly discriminate against patients."); Howe v. Hull, 873 F. Supp. 72, 78 (N.D. Ohio 1994) (stating that "[d]iscrimination in public accommodation can take the form of the . . . provision of unequal medical benefits based upon the disability"); Glanz v. Vernick, 756 F. Supp. 632, 638 (D. Mass. 1991) (stating that courts' unquestioning deference to doctors' medical judgments "would completely eviscerate § 504's function of preventing discrimination against the disabled in the health-care context").

306. 42 U.S.C. § 6102 (2001) provides: "[N]o person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving federal financial assistance." Unlike Title VI and Section 504, however, the Age Discrimination Act includes two exemptions from coverage and several exceptions to the Act's prohibition on age discrimination. *See* 42 U.S.C. § 6103(b)(2) (2001) (providing exemption for legally authorized programs or activities that provide benefits to individuals or allow participation based on age); 42 U.S.C. § 6103(c) (2001) (excluding most employment practices); 42 U.S.C. § 6103(b)(1) (2001) (providing that action does not violate Act when "(A) such action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of such program or activity; or (B) the differentiation made by such action is based upon reasonable factors other than age").

307. *Cf.* Jessica Dunsay Silver, *From Baby Doe to Grandpa Doe: The Impact of the Federal Age Discrimination Act on the "Hidden" Rationing of Medical Care*, 37 *CATH. U. L. REV.* 993, 1057-59 (1988) (arguing that reasoning of cases regarding hospitals' receipt of Medicare and Medicaid payments as federal financial assistance under Section 504 should be applied equally to Age Discrimination Act).

With respect to the Act's enforcement, the courts are divided on the availability of a private right of action for violating the Act.³⁰⁸ Courts rejecting a private right of action cite Congress's expectation that the Act "be enforced almost exclusively by" administrative action.³⁰⁹ Moreover, even when courts recognize a private right of action, a plaintiff alleging a violation of the Act must first exhaust the administrative remedies required by the statute or face dismissal of her claim.³¹⁰ Regardless of whether a plaintiff can bring a private damages action, the Act authorizes an "interested" person to seek injunctive relief against the discriminatory practice in federal court.³¹¹ As with injunctive relief under other statutes, the plaintiff must establish her standing.

Although the Age Discrimination Act does not expressly exclude medical decisions from its coverage, the prospect of applying the age discrimination law to medical treatment choices raises concerns similar to the concerns, discussed above,³¹² regarding the appropriateness of applying disability discrimination law to medical decisions. Age, like disability, may sometimes be a clinically relevant characteristic. Nonetheless, one commentator has argued forcefully against excluding medical decisions per se from the scope of the Act, noting that the Act effectively creates a presumption against the use of age as a factor in decision making when that use is based on "untested generalizations."³¹³ Upon examining the use of age as a criterion for heart transplant candidacy, however, even this commentator recognizes the challenge of applying a civil rights law to a physician's treatment decisions for an individual patient, as compared to a program's adoption of age as part of a blanket policy.³¹⁴ Thus, the sub-

308. Compare *Tyrrell v. City of Scranton*, 134 F. Supp. 2d 373, 384 (M.D. Pa. 2001) (finding no private right of action) and *Mittelstaedt v. Bd. of Trs. of Univ. of Ark.*, 487 F. Supp. 960, 973 (E.D. Ark. 1980) (same), with *Rannels v. Hargrove*, 731 F. Supp. 1214, 1221 (E.D. Pa. 1990) (finding private right of action) and *Stephanidis v. Yale Univ.*, 652 F. Supp. 110, 113 (D. Conn. 1986) (dismissing private action because defendant's activity was not covered by Act).

309. See *Tyrrell*, 134 F. Supp. at 381 (stating that "Congress expected that ADA would be enforced almost exclusively by regulatory action").

310. See *Belcher v. Ohio Dept. of Human Servs.*, 48 F. Supp. 2d 729, 738 (S.D. Ohio 1999) (barring age discrimination claim because plaintiff had not "exhausted [] administrative remedies"); *Popkins v. Zagel*, 611 F. Supp. 809, 812 (C.D. Ill. 1985) (same).

311. See 42 U.S.C. § 6104(e) (2001) (authorizing claimant to seek relief using injunction pursuant to this Act).

312. See *supra* notes 301-04 and accompanying text.

313. See *Silver*, *supra* note 307, at 1062 (arguing that test from Act is whether age is "valid criterion").

314. See *id.* (recognizing inherent challenges in applying civil rights law to medical treatment). She reasons:

To be sure, physicians should be given considerable discretion in exercising medical judgment, involving, as it does, a mix of art and science, and of intellect and intuition. The physician should have discretion to weigh the benefits and risks and choose the best treatment for the patient. But where a hospital establishes a treatment protocol that rations medical care, a physician who follows that protocol cannot claim immunity in or-

stantive applicability of the Act to individual diagnostic or therapeutic decisions remains unsettled.³¹⁵

5. *Plugging Gaps with State Anti-discrimination Laws*

The preceding description of the various federal statutes that potentially may apply to prohibit biased medical decisions reveals that existing civil rights laws may address some, but far from all, of the biased decision making that may occur. The inadequacy of federal law in addressing this form of discrimination is particularly evident when it comes to gender-biased medical decisions. Unless the doctor who made the biased decision either acted as an agent of the patient's employer, such that the treatment itself can be characterized as a term of employment, or made the decision as a program official at an academic medical center, gender-biased medical decisions appear to run afoul of no federal law. In some states, however, state laws prohibiting discrimination in places of public accommodation may fill this gap in coverage if "public accommodation" is defined to include medical offices.³¹⁶

Similarly, state laws conceivably could provide protection against discriminatory medical treatment decisions in areas, such as sexual orientation discrimination, where no federal protection exists. Several states prohibit discrimination by public accommodations on the basis of sexual orientation,³¹⁷ and these state laws might provide some redress to a patient whose physician's medical judgment was clouded by a bias against gays or lesbians.

der to preserve the autonomy of his or her medical judgment. The physician *is not deciding what is best for the individual patient*; rather, the physician has assumed the responsibility of choosing among patients to decide which patient should be provided care.

Id. at 1063 (emphasis added). The implication of the italicized language is that a physician's decision regarding what is best for the individual patient should not be scrutinized under the Act.

315. Accord Marshall B. Kapp, *De Facto Health-Care Rationing by Age: The Law Has No Remedy*, 19 J. LEGAL MED. 323, 346 (1998) (noting unclear congressional intent regarding federal scrutiny of individual treatment decisions).

316. See Rothenberg, *supra* note 12, at 1257 n.367 (citing N.Y. EXEC. LAW § 296(2)(a) (McKinney 1993)).

317. See, e.g., CONN. GEN. STAT. ANN. § 46a-81d (West 2001) (prohibiting discrimination based on sexual orientation in Connecticut); MINN. STAT. § 363.03 (2002) (prohibiting discrimination by public accommodations in Minnesota based on sexual orientation); N.J. STAT. ANN. § 10:5-4 (West 2002) (prohibiting employment discrimination by public accommodations in New Jersey based on sexual orientation).

B. *General Barriers to the Effectiveness of Civil Rights Approaches to Physician Bias*

1. *Lack of Coherence and Comprehensiveness*

The previous section's discussion of the various federal statutes that a plaintiff might employ to seek redress for a biased medical decision itself demonstrates a primary barrier to the efficacy of using civil rights statutes to address physician bias: The statutes themselves are diverse and characterized by variation with respect to the prohibited basis for discrimination, the entities subject to the law and enforcement mechanisms. Consequently, any attempted civil rights response must be tailored to the particular "flavor" of physician bias at issue in a specific case. The case of a racially biased medical decision prompts a different response from the case of gender-biased decision making, which prompts a different response from cases of disability or age-biased decisions. Thus, any response to the problem of physician bias grounded on federal civil rights laws will lack coherence. Moreover, because many instances of biased medical decisions do not constitute even an arguable violation of civil rights laws (for example, racially biased decisions made by a physician who receives no federal funding, or gender-biased decisions by most physicians), existing federal anti-discrimination laws do not offer a comprehensive approach to the problem of physician bias.

Admittedly, whether we view the civil rights approach's lack of coherence and comprehensiveness as problematic depends on our perspective on the problem of physician bias. *If* we view physician bias as objectionable only when the characteristic generating bias is a characteristic that also defines prohibited grounds for discrimination under federal law (e.g., race, sex, disability and age), and *if* we are satisfied that existing anti-discrimination laws sufficiently address those objectionable instances of biased medical decisions, only then would lack of coherence and comprehensiveness be untroubling. In other words, if we understand physician bias not as a general problem, but instead as a set of problems in specific contexts, then a set of legal responses targeted to those contexts may in fact be desirable. On the other hand, one who views biased medical decisions inclusively, as a general problem—albeit having particularly problematic manifestations for specific groups of patients—will find existing civil rights laws to be sorely inadequate for addressing the problem.

2. *Challenges of Proving Intentional Discrimination*

The lack of coherence and comprehensiveness of a civil rights approach to biased medical decision making calls into doubt that approach's effectiveness as a systematic response to physician bias. It is of no concern, however, to a patient whose claim of physician bias falls into one of the pockets of federal civil rights protection described above. To illustrate, an African-American Medicaid recipient who believes that his race influenced his doctor's choice for treating the patient's cardiac disease can easily

plead race discrimination by a recipient of federal funding and would encounter no coherence or comprehensiveness problems. This patient nonetheless faces a typically daunting—often well-nigh impossible—challenge of proving intentional discrimination on the doctor’s part.

This challenge is comprised of two aspects. First, the plaintiff must prove that discrimination in fact occurred—that he received different medical treatment because of his race (or other prohibited characteristic) and not for some other reason. Second, at least under Title VI, the plaintiff must prove that the physician’s discrimination was “intentional.” Although these two requirements are intimately related and typically are not assessed separately by courts, they may raise slightly different issues in the context of biased medical judgments. While courts have developed slightly varying standards for proving violations of the different anti-discrimination statutes discussed above, this section focuses on the challenge of proving a Title VI violation.³¹⁸

a. Proving Different Treatment Based on Race

A plaintiff who alleges that bias with respect to one of her personal characteristics affected her physician’s choice of treatment is essentially claiming that her physician provided her with a treatment different from what he would have provided in the absence of that characteristic. Thus, an individual patient’s claim of biased medical treatment is a claim of disparate treatment: The treatment choice was different because the patient was black, female, elderly or developmentally disabled. These claims are not likely to be framed effectively as disparate impact claims, which typically complain of the adversely disproportionate impact of a policy or practice that is facially neutral.³¹⁹ Although some medical treatment decisions may be influenced by such policies or practices employed by institutional providers, payers or regulatory bodies,³²⁰ individual physicians

318. I choose Title VI’s prohibition on racial discrimination for this focus for two reasons. First, the most plentiful evidence of some level of physician bias in the medical literature is regarding bias based on the patient’s race. *See supra* notes 52-57 and accompanying text (describing studies examining race and medical treatment). Second, Congress patterned Title IX, the Age Discrimination Act, and Section 504 on Title VI, and courts applying those laws regularly look to judicial constructions of Title VI for guidance.

319. In addition to the fact that a biased medical decision does not fit with the typical understanding of a disparate impact claim, framing the charge as one of disparate impact would render individual patients unable to bring private actions for a Title VI violation. Although the regulations issued by HHS enforcing Title VI prohibit disparate impact discrimination, the Supreme Court has ruled that no private right of action exists to enforce the disparate impact regulations. *See Alexander v. Sandoval*, 532 U.S. 275, 286 (2001) (stating no private right of action exists). Thus, enforcement against recipients of federal funds who employ policies or practices that have a disparate racial impact is left to the agency that disburses the funds. To date, HHS has not been aggressive in enforcing Title VI in instances involving alleged disparate impact in the health care field.

320. *See, e.g., Ian Ayres et al., Unequal Racial Access to Kidney Transplantation*, 46 VAND. L. REV. 805, 855-56 (1993) (arguing that antigen-matching rules employed

making treatment decisions typically form their decisions on a patient-by-patient basis without employing blanket policies directing the treatment choices.³²¹

How can a patient who alleges such different treatment prove that she in fact received different treatment because of her race? For example, let us hypothesize that a young black woman went to a hospital's emergency room with a broken leg. There, despite her complaints of significant pain, the emergency room doctor failed to provide her with any pain medication. Following the incident, she sues for a violation of Title VI, asserting that the physician's failure to provide her with adequate analgesia was based on her race.³²² Courts hearing discrimination claims allow plaintiffs to prove their cases either by using direct evidence of discrimination or by producing circumstantial evidence of discrimination. Direct proof in the hypothetical case would be evidence that the emergency room physician, in deciding whether to prescribe pain medication, in fact weighed the patient's race as a factor in his decision.³²³ It is hard to imagine that a plaintiff often would be able to prove that the physician told her (or anyone else) that he was ordering or denying a particular treatment because she

by government contractor as part of process of allocating kidneys for transplantation disproportionately and adversely impact Blacks which may violate Title VI).

321. Of course, one can imagine a situation in which a physician employs a treatment protocol for a particular condition that leads the physician to provide all his patients—of whatever race—diagnosed with that condition with the same treatment. In such a case, a disparate impact claim could conceivably arise if it were proved that the treatment was generally ineffective for Black patients. Similarly, a disparate impact claim might lie if a physician followed a screening protocol for all his patients (thus treating all patients the same with respect to when the screening should occur), but the screening protocol did not take into account risk factors commonly shared by Black patients that would make more aggressive screening appropriate for them. The bulk of the studies described in Part II, however, deal with situations in which patients in different racial groups were provided with different therapeutic or diagnostic procedures.

322. This hypothetical is based loosely on Knox H. Todd et al., *Ethnicity and Analgesic Practice*, 35 ANNALS OF EMERGENCY MED. 11, 12-14 (2000) (describing study undertaken in order to determine whether black patients with fractures in their extremities have lower likelihood of receiving analgesic than their white patient counterparts), discussed in Part IIB2d *supra*.

323. *Cf.* Walker v. Glickman, 241 F.3d 884, 888 (7th Cir. 2001) (“[r]emarks and other evidence that reflect a propensity by the decision maker to evaluate employees based on illegal criteria will suffice as direct evidence of discrimination even if the evidence stops short of a virtual admission of illegality”). A plaintiff's direct evidence of discrimination, however does not necessarily compel a finding for the plaintiff. *See id.* at 889 (describing how plaintiff, Walker, submitted three pieces of what he considered to be direct evidence of discrimination with district court finding that such evidence did not represent direct evidence of retaliation). In some cases, notwithstanding direct evidence of discrimination, the overall body of evidence may compel a finding that the decision at issue was motivated by factors other than discrimination. *See e.g.*, Sanghvi v. St. Catherine's Hosp., 258 F.3d 570, 575 (7th Cir. 2001), *cert. denied*, 122 S. Ct. 923, 929 (2002) (finding direct evidence to be “no more than a scintilla of evidence of racial discrimination and insufficient to permit a reasonable jury to return a verdict for [plaintiff]”).

was black.³²⁴ Nor is it likely that a physician's notes in a patient's medical chart would explicitly draw such a causal connection. Thus, direct evidence of different treatment based on race is likely to be quite rare.

Lacking direct evidence of race-based differential treatment, the patient may resort to circumstantial evidence to prove racially based discrimination. Circumstantial evidence allows a fact finder to infer from directly proven facts that the legally significant fact also exists.³²⁵ In essence, a case based on inferential evidence asks the factfinder to conclude that discrimination is the most plausible explanation for a particular proven set of facts. The Supreme Court has established a structure for litigating individual disparate treatment cases based on inference. Although the well-known *McDonnell Douglas* burden-shifting paradigm³²⁶ was developed in an employment discrimination case under Title VII of the Civil Rights Act, courts have adapted it to different contexts and different statutory schemes, including Title VI.³²⁷

324. An example of such evidence in the employment context can be found in *Slack v. Havens*, 7 FEP 885, 887 (S.D. Cal. 1973), *aff'd as modified*, 522 F.2d 1091, 1093 (9th Cir. 1975) (finding direct evidence of discrimination in supervisor's comment that "colored people were hired to clean because they clean better").

325. See *Harris v. Marsh*, 679 F. Supp. 1204, 1279 n.120 (E.D.N.C. 1987) (citing *Radomsky v. United States*, 180 F.2d 781, 783 (9th Cir. 1950) ("Circumstantial evidence is that which establishes the fact to be proved only through inference based on human experience that a certain circumstance is usually present when another certain circumstance or set of circumstances is present. Direct evidence establishes the fact to be proved without the necessity for such inference.").

326. See *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 802-05 (1973). The Court established the process for proving a Title VII claim inferentially as follows:

The complainant . . . must carry the initial burden under the statute of establishing a prima facie case of racial discrimination. This may be done by showing (i) that he belongs to a racial minority; (ii) that he applied and was qualified for a job for which the employer was seeking applicants; (iii) that, despite his qualifications, he was rejected; and (iv) that, after his rejection, the position remained open and the employer continued to seek applicants from persons of complainant's qualifications The burden then must shift to the employer to articulate some legitimate, nondiscriminatory reason for the employee's rejection [Even if the employer articulates such a reason], the inquiry must not end here [The plaintiff must] be afforded a fair opportunity to show that [the employer's] stated reason . . . was in fact pretext.

Id. at 802, 804.

327. See, e.g., *Hankins v. Temple Univ.*, 829 F.2d 437, 440 (3d Cir. 1987) (applying *McDonnell Douglas* burden shifting paradigm); *McKie v. New York Univ.*, 2000 WL 1521200 *3 n.1 (S.D.N.Y. 2000) ("Title VI claims are governed by the same McDonnell-Douglas burden shifting inquiry applied to claims brought under Title VII"). Courts have also employed this burden-shifting approach in cases brought under § 504. See *Pushkin v. Regents of Univ. of Colo.*, 658 F.2d 1372, 1385 (10th Cir. 1981) (using McDonnell Douglas to determine "whether an individual has been subjected to 'disparate treatment,' " therefore eligible for § 504 claim).

It is unclear the extent to which *McDonnell Douglas's* burden-shifting approach makes sense applied to claims alleging discriminatory medical treatment. Cf. *Lesley v. Hee Man Chie*, 250 F.3d 47, 56 n.10 (1st Cir. 2001) (noting that use of burden shifting paradigm has been rejected in ADA reasonable accommodation cases). To begin, in most cases physicians do not make treatment decisions in the

So, to continue the hypothetical case described above, even if the patient who was denied analgesia for the pain from her broken leg cannot produce direct evidence that the doctor withheld analgesia because of her race, she nonetheless can seek to prove that her race is the most plausible explanation for the denial. She might seek to show that when other non-black patients came to the emergency room with a fractured leg and complained of pain, the defendant physician ordered analgesia. Statistical proof that this doctor tends to order pain medication only for non-black emergency room patients with fractured limbs could satisfy the plaintiff's burden of showing a prima facie case of discrimination.³²⁸ Similarly, she might seek to introduce evidence of statements or actions by the physician demonstrating that the physician harbored prejudice against African Americans or that he entertained stereotypes about their proclivity towards drug-seeking behavior.

Of course, under the burden-shifting paradigm the defendant physician retains the opportunity to present evidence of a non-race-based reason for failing to prescribe analgesia. For example, the physician might assert that the plaintiff did not complain of pain forcefully enough to draw his attention; he might claim that the patient was intoxicated at the time that she came to the emergency room and that therefore analgesia was contraindicated; or he may allege that the patient was uninsured and that the emergency department had a policy of not administering analgesia to uninsured patients who could not give proof of their ability to pay. Even if the physician articulates a legitimate, non-discriminatory reason for failing to prescribe analgesia, the plaintiff patient still has the opportunity to try to convince the trier of fact that the proffered reason was not the real reason, but was instead a pretext for discrimination.³²⁹

context of patients competing directly for a limited resource, such as a job. Thus, it would make no sense to require the plaintiff, as part of his prima facie case, to show who received the treatment that he did not receive. Even if the *McDonnell Douglas* employment-focused approach cannot sensibly be imported whole cloth into medical treatment cases, courts may look to the case in considering the parties' respective burdens of production and proof.

328. In the Title VII context, statistical evidence of discrimination is typically presented in a case brought by the Equal Employment Opportunity Commission (EEOC) alleging the employer's pattern or practice of discriminating against a large number of employees. See Ann C. McGinley, *Viva La Evolucion!: Recognizing Unconscious Motive in Title VII*, 9 CORNELL J. L. & PUB. POL'Y 415, 465-66 (2000) (stating that in action brought by EEOC, government must demonstrate by preponderance of evidence that employer intentionally discriminated against class of plaintiffs). So too, one could imagine DHHS using statistical evidence in enforcing Title VI against physicians who discriminate against a large number of patients. An individual plaintiff, however, may also present such evidence in order to demonstrate a physician's bias. Of course, the fact of a physician's bias does not necessarily mean that the physician discriminated against this plaintiff, but statistical evidence indicating bias could certainly provide indirect evidence of discrimination.

329. See *McDonnell Douglas*, 411 U. S. at 805 n.18 ("[the plaintiff] must be given a full and fair opportunity to demonstrate by competent evidence that

Describing the process by which a plaintiff might seek to prove a Title VI violation using inferential proof is straightforward enough, but such a plaintiff is likely to encounter several hurdles in trying to complete the above course. First, in the likely absence of a “smoking gun” showing direct evidence of racially motivated different treatment³³⁰ or evidence of the physician’s generalized prejudice, a patient will need to employ statistical evidence to make her case. While statistical evidence can be difficult and expensive to develop in any case, the difficulty is multiplied when the necessary data involve the medical treatment of other patients.

As discussed above, courts are generally unwilling to allow discovery of the medical records of non-party patients in medical malpractice litigation brought by a patient.³³¹ Some courts, though, will allow discovery if the plaintiff makes the case that information contained in non-party medical records is relevant and that all identifying information regarding the non-party patient can be redacted.³³² In those cases, the court may find that the balance between the patient’s need for the information and the risk of violating the confidentiality of medical records tips in the plaintiff’s favor. In addition, a court may conduct the weighing process somewhat differently in a case alleging the violation of a civil rights law, for then a public interest must be factored into the calculation.

Although research reveals no published decision addressing the discoverability of patient records in a civil rights action, courts have addressed an analogous issue in the context of discrimination claims brought by physicians who have been subjected to adverse peer review action. The records of medical peer review bodies are generally protected from discovery by state law evidentiary privileges; the purpose of this protection is both to encourage physicians to participate in reviewing the competency and professionalism of their peers and to enable the free and frank sharing of information as part of that process.³³³ In a number of

whatever the stated reasons [for the defendant’s actions], the decision was in reality racially premised.”)

330. *Cf. Garcia v. S.U.N.Y. Health Sciences Center of Brooklyn*, 2001 WL 1159970, at *9 (2d Cir. 2001) (noting, in context of disability discrimination action, that “direct proof of [discriminatory animus] will often be lacking: smoking guns are rarely left in plain view”).

331. *See supra* note 233 and accompanying text.

332. *See, e.g., Amente v. Newman*, 653 So. 2d 1030, 1032 (Fla. 1995) (permitting discovery of information from redacted medical records of nonparty patients).

333. *See FURROW ET AL., supra* note 176, at 133-34 (noting benefits that physicians receive through free circulation of peer evaluation). Many state laws also seek to encourage peer review by making peer review participants immune from liability flowing from their participation in the peer review process. *See id.* at 140-43 (describing trend among states to protect physicians from liability through such legislation). Similarly, the Federal Health Care Quality Improvement Act of 1986 includes provisions shielding peer review participants from liability for damages, as long as the peer review process satisfies certain statutory standards requiring reasonableness. *See* 42 U.S.C. § 11112(a) (2001) (stating, in part, that professional review action must be taken “in reasonable belief that the action was in furtherance of quality health care [and] after reasonable effort to obtain facts of the mat-

recent cases, however, courts have found that the medical peer review privilege does not prevent discovery of peer review records in federal actions alleging civil rights violations.³³⁴ Indeed, in one case in which a physician alleged that the termination of his staff privileges was motivated by his race and national origin, the court allowed the physician to discover not only his own peer review records, but also records containing peer review information regarding other physicians at the hospital.³³⁵ In declining to recognize the evidentiary privilege in this context, the court reasoned:

The evidence [the plaintiff] seeks is crucial to his attempt to establish that he has been the subject of disparate treatment on the basis of race and ethnicity. To prove his allegations of disparate treatment, [the plaintiff] must compare the proceedings in his case to those involving similarly situated physicians. The interest in facilitating the eradication of discrimination by providing perhaps the only evidence that can establish its occurrence outweighs the interest in promoting candor in the medical peer review process.³³⁶

A plaintiff seeking to discover evidence of a physician's treatment of other similarly situated patients in a civil rights action thus may be able to effectively analogize his request for discovery to the peer review context in which courts have refused to protect records from discovery.

Yet the difficulty of obtaining evidence from which discrimination might be inferred is not the only barrier to recovery faced by a patient-plaintiff suing a physician for biased medical treatment under a federal anti-discrimination law. Even if the plaintiff is able to present statistical evidence derived from patient records showing, for example, the physician's pattern of treating black patients differently from non-black patients, the physician-defendant undoubtedly will assert that some factor, or combination of factors, other than race led him to choose the treatment provided to this particular patient. Just as the complexity of clinical decision making makes it difficult to eliminate potentially confounding vari-

ter."). Significantly, Congress did not make HCQIA's statutory shield fully protective; it provided that civil rights actions would not be precluded by the law. See 42 U.S.C. § 11111 (2001).

334. See, e.g., *Mattice v. Memorial Hospital of South Bend*, 203 F.R.D. 381, 384-85 (N.D. Ind. 2001) (allowing discovery of peer review records in ADA action); *Marshall v. Spectrum Med. Group*, 198 F.R.D. 1, 5 (D. Me. 2000) (allowing discovery of peer review records in ADA action); *Holland v. Muscatine Gen. Hospital*, 971 F. Supp. 385, 392 (S.D. Iowa 1997) (allowing discovery of peer review records in Title VII action); *Johnson v. Nyack Hosp.*, 169 F.R.D. 550, 562 (S.D.N.Y. 1996) (allowing discovery of peer review records when value of records as evidence outweighs any harm to any party involved).

335. See *Virmani v. Novant Health Inc.*, 259 F.3d 284, 285-86 (4th Cir. 2001) (alleging race and national origin discrimination under 42 U.S.C. § 1985).

336. See *id.* at 289 (refusing to grant privilege that would allow plaintiff to discover peer review evidence in support of claim).

ables in researching the causes of health treatment disparities,³³⁷ so too does that complexity complicate the civil rights plaintiff's task in isolating race (or any other group characteristic) as a causative factor.³³⁸ Because medicine is an inexact science and physicians typically take a wide variety of facts into account in exercising clinical judgment, the physician's assertion of a legitimate non-discriminatory reason for the selected treatment will likely prove difficult to rebut without some direct evidence of bias. Thus, even a plaintiff who is allowed to admit all available evidence suggesting discriminatory medical treatment often will fail to persuade the fact finder that any treatment differential was in fact based on race, rather than some other factor.

b. Proving that Discrimination was Intentional

The foregoing discussion has focused on the challenge inherent in trying to prove that a patient's race did in fact influence a physician's decision regarding the medical treatment provided to (or denied) the plaintiff. But even a patient-plaintiff who can convince a court that her physician provided her with different medical treatment because of her race will not necessarily succeed on her civil rights claim. In order to succeed, she must also prove that the discrimination was intentional. The Supreme Court recently reaffirmed that a private plaintiff suing to enforce Title VI must show intentional discrimination.³³⁹ According to the Court, Title VI itself "proscribes only those racial classifications that would violate the Equal Protection Clause or the Fifth Amendment."³⁴⁰ Consequently, a plaintiff must point to evidence of racially discriminatory intent or purpose.³⁴¹ So how can a plaintiff show that her physician, when ordering different medical treatment for the plaintiff because of her race, *intentionally* discriminated?

Admittedly, the question posed rings confusing: After all, isn't all disparate treatment racial discrimination intentional? How can one person *unintentionally* treat another differently *because of* the other's race? Doesn't the causal relationship indicated by "because of" also demonstrate

337. See Epstein, *supra* note 34, at 1537 (stating that despite large quantity of evidence that exists suggesting racial discrimination in use of surgical procedures, cause of such discrimination remains unknown).

338. As will be discussed more fully below, this complexity has led several courts to sound a note of caution about applying civil rights statutes to medical decisions. See Part VB3 *infra*.

339. See *Alexander v. Sandoval*, 532 U.S. 275, 280 (2001) (holding that no private right of action is available to enforce disparate impact regulations promulgated under § 602 of Title VI and reiterating that § 601 requires proof of intentional discrimination); see also *Guardian's Ass'n v. Civil Serv. Comm'n*, 463 U.S. 582, 610 (1983) (holding that liability for damages in private action under Title VI requires proof of intent).

340. See *Alexander*, 532 U.S. at 280 (explaining which racial preferences are actionable under Title VI).

341. See *McCleskey v. Kemp*, 481 U.S. 279, 288 (1987) (stating that statistics alone are insufficient evidence to prove discriminating intent or purpose).

the actor's intent to discriminate? In many cases, the answer to the final question is "yes." In others words, the actor found to have considered race in making a decision is also found to have done so consciously and, therefore, intentionally. If she knows she is taking race into account in making her decision, then she is intentionally discriminating. But what if she is *not* aware that she is taking race into account?

The question of what exactly the Supreme Court means when it requires proof of "intentional" discrimination has occupied a number of scholars and produced a rich literature examining whether liability for violating anti-discrimination laws should extend to actors whose acts of differential treatment flow from subconscious biases. The seminal work in this area is Charles Lawrence's *The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism*,³⁴² which draws on psychiatric and psychological literature to argue that most contemporary racism is embodied more in unconscious stereotyping than in conscious bigotry. Lawrence recognizes that existing jurisprudence effectively relegates acts influenced by unconscious racial stereotyping to a sort of intent limbo:

Traditional notions of intent do not reflect the fact that decisions about racial matters are influenced in large part by factors that can be characterized as neither intentional—in the sense that certain outcomes are self-consciously sought—nor unintentional—in the sense that the outcomes are random, fortuitous, and uninfluenced by the decisionmaker's beliefs, desires, and wishes.³⁴³

Other scholars have built on Lawrence's work to examine the legal treatment of discrimination that might be deemed "negligent"³⁴⁴ or "accidental."³⁴⁵

A central premise of much of this literature reflects theories, developed by cognitive psychology, that characterize stereotyping as a natural, and indeed predictable, human response to the richness of information and stimuli in the surrounding environment.³⁴⁶ Thus, according to cogni-

342. 39 STAN. L. REV. 317 (1987).

343. See *id.* at 322 (suggesting that racism is so ingrained that it can be classified neither as intentional nor as unintentional).

344. See David B. Oppenheimer, *Negligent Discrimination*, 141 U. PA. L. REV. 899, 967-72 (1993) (setting forth theory of negligent discrimination under Title VII).

345. See Wax, *supra* note 165, at 1152-53 (examining whether Title VII should extend to "unconscious disparate treatment" in workplace).

346. See Linda Hamilton Krieger, *The Content of our Categories: A Cognitive Bias Approach to Discrimination and Equal Employment Opportunity*, 47 STAN. L. REV. 1161, 1187 (1995). She writes: "[The] central premise of social cognition theory [is] that cognitive structures and processes involved in categorization and information processing can in and of themselves result in stereotyping and other forms of biased intergroup judgment According to this view, stereotypes . . . are cognitive mechanisms that *all* people, not just 'prejudiced' ones, use to simplify the task of perceiving, processing, and retaining information about people in memory."

tive theory, people whose mindset includes stereotypes or biases are not necessarily “prejudiced” against those groups about whom their minds have formed biases; indeed, people are unlikely to be aware of the bias’s existence or its influence on their decisions.³⁴⁷ While a recent review of social science research into stereotyping and discrimination indicates that more recent studies find that motivation and affect may also contribute to unconscious discrimination, the reviewer still concludes: “No matter how the interaction of cognitive, affective and motivational factors occurs, social science research demonstrates that race and gender bias and prejudice resulting in discriminatory behavior are the result of unconscious, as well as conscious, phenomena.”³⁴⁸ According to these scholars, much of contemporary racial discrimination occurs without the discriminating decision maker being aware of race’s influence on his decisions.³⁴⁹

Most of the legal scholars who have concentrated their attention on the legal status of unconscious discrimination have done so in the context of asking whether liability for employment discrimination under Title VII should extend to unconscious disparate treatment of employees on statutorily forbidden grounds. These scholars have reached varying conclusions on that question,³⁵⁰ and the courts have not clearly resolved the question either.³⁵¹ Moreover, although Charles Lawrence’s article itself

See id. at 1187-88 (suggesting human biological means for unconscious formation of stereotypes).

347. *See id.* at 1188 (asserting that unintentional, unconscious biases “sneak up on” and distort decision maker’s cognition).

348. *See* McGinley, *supra* note 328, at 425 (proposing that discrimination and bias are pervasive among humans).

349. Ann McGinley also discusses the research describing how gender “schemas,” or stereotyped role expectations, unconsciously influence employers’ evaluations of women’s job performance. *See id.* at 434-41 (discussing “gender schemas” that undervalue women in workplace).

350. *Compare* Wax, *supra* note 165, at 1226 (concluding that extending Title VII liability to “unconscious disparate treatment” in workplace would not serve principal goals of liability scheme in a cost-effective manner and is therefore inadvisable), *with* McGinley, *supra* note 328, at 491 (concluding that “if Title VII is to fulfill its purpose, . . . [t]he law can no longer limit its definition of discrimination to conscious discriminatory behavior; the definition should also include behavior that is rooted in unconscious prejudice.”).

351. *See* Michael Selmi, *Proving Intentional Discrimination: The Reality of Supreme Court Rhetoric*, 86 GEO. L.J. 279, 287 (1998) (asserting that “even though the Court has rarely found a violation when the evidence pointed toward subtle, rather than overt, discrimination, the Court’s definition of intentional discrimination is broad enough to encompass most forms of subtle or unintentional discrimination . . .”). Selmi further argues that the Court’s definition of intent most closely reflects a causation-focused, rather than animus-focused approach, but that the Court, in its decisions, has “never fully embraced its own rhetoric.” *See id.* at 286 (suggesting that Court in recent past has usually insisted that defendant’s discrimination be of clear and intentional nature for plaintiff to succeed in action). Martha Chamallas notes that although “most often courts also insist that there be an additional showing that the disparate or different treatment is the product of deliberate or conscious decision making,” in some Title VII disparate treatment cases it is enough to show that race or gender “caused” the employer’s different treatment of the plain-

focused on subconscious racism's role in equal protection analysis,³⁵² the issue of whether unconscious discrimination might qualify as intentional discrimination sufficient to show a violation of Title VI and other Spending Clause legislation has not been extensively studied.³⁵³

A full exploration of whether courts should find a Title VI violation when a recipient of federal funding treats a person differently because of his race, but is not conscious of the racial motivation, lies beyond the scope of this Article. This is the very question, however, that a court hearing a Title VI claim alleging racially biased medical decision making may be called upon to answer. It is doubtless possible that some physicians making clinical decisions consciously take a patient's race (or sex, age or disability) into account in a manner irrelevant to the patient's need for medical treatment. These physicians would appear to discriminate "intentionally" under any meaning of the word. Most commentators in the medical literature, however, concur that—to the extent that physician bias plays a role in producing documented disparities in the levels of different treatments provided—the bias is probably largely subconscious, so that physicians' judgments may be influenced by biases without the physicians' being aware of that influence.³⁵⁴

tiff, even if the employer was not aware of the operation of the race or gender factor. See Martha Chamallas, *supra* note 241 at 748-49 (2001) (stating that some courts, such as those involved in Title VII actions, have regarded arguments suggesting that unconscious discrimination occurred as sufficient to allow plaintiff to prevail). From this she concludes, "even nominally within an intentional discrimination framework, there may be a shifting emphasis from state of mind to causation." See *id.* at 754 (supporting her argument that some courts tend to view unconscious discrimination attributed to human cognitive mechanisms as sufficient to enable one to make out successful action for discrimination).

352. See Lawrence, *supra* note 342, at 355 (urging courts who hear Equal Protection Challenges to consider unconscious racism "underlying much of the racially disproportionate impact of government policy").

353. Cf. *United Steelworkers of America, AFL-CIO-CLC v. Weber*, 443 U.S. 193, 206 n.6 (1979) (noting that because Title VI represents "exercise of the federal power over a matter in which the government is already directly involved" and was enacted pursuant to Spending Clause, it cannot be read *in pari material* with Title VII, which was enacted pursuant to commerce power in order to regulate "purely private decision making"). Based on this statement, Sidney Watson has argued:

Courts should not be reluctant to scrutinize the operation of federally funded programs. Title VI is a spending power statute. It does not regulate but places conditions on the expenditure of federal money. As a condition of receipt of federal Medicaid and Medicare money, hospitals and other health care providers guarantee that they will not use policies and practices that have the effect of excluding minority patients. Courts should hold health care providers to their promise.

Watson, *supra* note 250, at 978. This argument could be extended to assert that providers who choose to accept federal funds can justifiably be held to the high standard of taking steps to avoid any "unconscious" or "inadvertent" or "negligent" discrimination.

354. See *supra* notes 91-93 and accompanying text.

What result then follows—to return to the hypothetical posed earlier—if the fact finder concludes from the evidence that no factor other than race adequately explains why the emergency room physician failed to provide adequate analgesia to the black woman with a broken leg, but the fact finder also believes that the physician may not have been consciously aware that the patient’s race influenced his decision?³⁵⁵ Scholars have laid the theoretical foundation for arguing that motivation or causation should be the determinative factor in identifying “intentional discrimination” (i.e., that discrimination is intentional if race motivated or played a causal role in producing the complained-of behavior) and that a plaintiff alleging discrimination should not be required to prove a conscious decision to discriminate.³⁵⁶ Whether a plaintiff alleging biased medical treatment could succeed in persuading a court to construct a decision upon this foundation, however, is another matter. Thus, even a plaintiff who can garner evidence sufficient to convince a court that her race influenced her doctor’s choice of medical treatment may not be able to persuade the court that her physician’s discrimination was intentional.

3. *Judicial Reluctance to Intrude on Doctors’ Judgment and State Regulation*

A final problem with any attempt to invoke federal civil rights laws in response to biased medical decisions lies in the courts’ reluctance to apply federal anti-discrimination law to a claim that the court views as essentially alleging poor quality or inappropriate medical care. This reluctance flows from two related sources: First, the courts are disinclined to take on the task of second-guessing professional medical judgment. Second, to the extent that a claim entails assessing the quality of care provided, courts emphatically proclaim that any such assessment should be conducted not as a matter of federal law, but as a matter of state law regulating the quality of medical care, i.e., as a medical malpractice claim.

As an initial matter, one might wonder why courts would characterize an action alleging biased medical decisions as essentially a complaint about poor quality care. This characterization, however, is in some sense accurate. It stands to reason that a patient who believes that she received superior medical treatment because of her race (i.e., she was discriminated “in favor of,” rather than “against”) is unlikely to sue her physician.

355. Of course, presenting evidence to compel such a factual conclusion remains a daunting challenge, but perhaps no more so than the basic challenge of showing that race (or another forbidden characteristic) influenced the decision made, as discussed in the previous section. In either case, absent an admission by the defendant, the plaintiff is unlikely to produce evidence on the question whether the physician was conscious or unconscious of the influence of his bias on his clinical decisions. This difficulty of proving an individual’s state of mind provides another argument for shifting the focus of judicial inquiry from the decision maker’s subjective intent to the question of causation. *See Chamallas, supra* note 241, at 754 (discussing shift of emphasis from state of mind to causation).

356. *See Wax, supra* note 165, at 1158 (focusing on research that has been performed that points to unconscious basis for development of stereotypes).

Accordingly, complaints of discriminatory medical judgments are likely to include—as part of the claim that the plaintiff was treated differently from other similarly situated patients—a claim that the treatment received was somehow inferior to and of poorer quality than that received by other patients. Indeed, commentators too have characterized evidence of racial disparities in medical treatment as evidence of poor quality of care.³⁵⁷ Recognition of the quality aspect implicit in a claim of discriminatory medical treatment, however, does not necessarily compel a court's unwillingness to address the alleged discrimination. So what explains the courts' reluctance?

One explanation lies in the courts' discomfort with questioning the soundness of medical judgment reflected in a medical treatment decision under any rubric other than medical malpractice. This discomfort is evident in cases alleging that medical choices violated disability discrimination laws.³⁵⁸ For example, in deciding that Section 504 of the Rehabilitation Act did not extend to medical decisions regarding disabled newborns, the Second Circuit rejected the government's assertion that a disabled newborn who had been denied life-saving surgery had thereby been subjected to discrimination. The court found that characterizing the medical decision as discriminatory took

an oversimplified view of the medical decisionmaking process. Where the handicapping condition is related to the condition(s) to be treated, it will rarely, if ever, be possible to say with certainty that a particular decision was 'discriminatory' Beyond the fact that no two cases are likely to be the same it would invariably require lengthy litigation primarily involving conflicting expert testimony to determine whether a decision to treat, or not to treat . . . was based on a 'bona fide medical judgment', however that phrase might be defined.³⁵⁹

Some other courts have followed the Second Circuit's lead and have simply declined to apply disability discrimination law to medical treatment decisions.³⁶⁰

357. See *Fiscella*, *supra* note 43, at 2579; *Watson*, *supra* note 13, at 203.

358. Judicial reluctance to intrude on medical judgments may also appear in cases alleging discrimination in medical staff privilege decision making. See *United States v. Harris Methodist Fort Worth*, 970 F.2d 94, 99 (5th Cir. 1992) (emphasizing Congressional intent that "federal regulation should not lose sight of its ultimate goal of facilitating the delivery of medical care," and that "regulation may not operate in such a way as to 'supervise or control' medical practice or hospital administration.").

359. See *United States v. Univ. Hosp., State Univ. of New York at Stony Brook*, 729 F.2d 144, 157 (2d Cir. 1984) (arguing that it is difficult to establish proof of discriminatory behavior of doctor against newborn in this context).

360. See *Grzan v. Charter Hosp. of N.W. Ind.*, 104 F.3d 116, 123 (7th Cir. 1997) (holding that plaintiff did not have civil rights action, but did have action in tort); *Toney v. United States Healthcare, Inc.*, 838 F. Supp. 201, 204 (E.D. Pa. 1993), *aff'd*, 37 F.3d 1489 (3rd Cir. 1994) (holding that "a determination by a phy-

Moreover, even those courts willing to entertain claims that medical choices violate disability discrimination law have shown significant deference to physicians' exercise of medical judgment.³⁶¹ For example, in the recent case *Lesley v. Hee Man Chie*,³⁶² the First Circuit addressed directly the question of the appropriate level of respect to be paid to medical decisions and sought to steer a middle course between "a rule giving physicians complete deference and a rule requiring a full-fledged inquiry into their diligence."³⁶³ The "middle ground" standard chosen, however, remains quite deferential, allowing the plaintiff to challenge a medical decision under the Rehabilitation Act only if she can "show[] the decision to be devoid of any reasonable medical support."³⁶⁴ As a practical matter, because of the wide variations in medical treatment patterns, only the most egregiously discriminatory (or negligent) medical decision is likely to pass the test of being "devoid of any reasonable medical support." Under this standard, if a physician can point to any reasonable medical support for her treatment choice, she avoids liability even if bias in fact influenced her choice.

The court's analysis in *Lesley* also highlights the second aspect of courts' lack of enthusiasm for applying federal anti-discrimination laws to medical treatment decisions. Not only do the courts wish to avoid second-guessing a medical judgment, they also want to avoid applying federal statutes to an area of traditional state regulation: medical malpractice law. As partial justification for its refusal to scrutinize closely the defendant doctor's medical decision, the *Lesley* court reasoned:

[C]ourts should not probe so far into a doctor's referral decision as to inquire whether it was the correct or best decision under the circumstances, or even whether it met the standard of care for the profession. Lest questions of medical propriety be conflated with questions of disability discrimination, it must take

sician of when her regular patient's condition warrants an additional office visit is a medical treatment decision not subject to judicial review"); *Johnson by Johnson v. Thompson*, 971 F.2d 1487, 1493-94 (10th Cir. 1992) (declaring intention to follow Second Circuit). *But see* *Glanz v. Vernick*, 756 F. Supp. 632, 638 (D. Mass. 1991) (recognizing "some merit to the argument that the court should defer to a doctor's medical judgment," but concluding that evidentiary framework of shifting burdens of proof "properly balances deference to sound medical opinions with the need to detect discriminatory motives") (*citing* *Pushkin v. Regents of the Univ. of Colo.*, 658 F.2d 1372 (10th Cir. 1981)).

361. *See, e.g.*, *Jairath v. Dyer*, 972 F. Supp. 1461, 1470 (N.D. Ga. 1997) ("The Court finds no reason to penalize a doctor for exercising caution in his medical judgments.").

362. 250 F.3d 47 (1st Cir. 2001).

363. *Id.* at 53, 55 ("[T]his case requires us to explore the extent to which the Rehabilitation Act contemplates judicial scrutiny of alleged exercises of medical judgment.").

364. *See id.* at 55 (discussing patient's right to bring suit under Rehabilitation Act).

more than a mere negligent referral to constitute a Rehabilitation Act violation.³⁶⁵

Thus, if a plaintiff alleging a discriminatory medical treatment decision stresses too strongly the inferiority of the treatment provided, he risks the court's rejecting his claim as an attempt to federalize malpractice law.³⁶⁶

This judicial discomfort with applying federal statutes to patients' claims that include any complaint about the quality of medical care received is not confined to the realm of anti-discrimination claims. For example, courts hearing cases alleging violations of the Emergency Medical Treatment and Active Labor Act³⁶⁷—the federal “anti-dumping” law for hospitals—have consistently proclaimed that the Act was not intended to create a federal malpractice action for negligent screening or treatment in hospitals and thus does not apply to complaints of negligent or poor quality care provided by emergency department personnel.³⁶⁸ Similarly, the Supreme Court, in rejecting a patient's claim that a managed care organization's use of financial incentives for physicians breached fiduciary duties under the Employee Retirement Income Security Act, recently emphasized the risk of replicating state malpractice actions: “[F]or all practical purposes, every [such] claim of fiduciary breach by an HMO physician . . . would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians.”³⁶⁹ In light of these cases, it would hardly be surprising to find courts presented with federal civil rights actions alleging discrimi-

365. *See id.* at 54 (avoiding conflict of state malpractice and federal civil rights actions).

366. *See Bryant v. Madigan*, 84 F.3d 246, 249 (7th Cir. 1996) (finding that ADA did not create “federal malpractice claim” for disabled persons who were negligently treated).

367. 42 U.S.C. § 1395dd (2001). The Act essentially requires that hospitals that receive Medicare funds and that have emergency departments provide an appropriate medical screening exam to any person who comes to the emergency department and, for those persons who are found to have an emergency medical condition, to either treat the person in order to stabilize the condition or transfer the person to another hospital in accordance with the terms of the Act. *See* 42 U.S.C. §§ 1695dd(a), (b) (listing specifics of regulation pertaining to examination and treatment for emergency medical conditions).

368. *See, e.g., Marshall v. East Carroll Parish Hosp.*, 134 F.3d 319, 322 (5th Cir. 1998) (agreeing that “EMTALA . . . was not intended to be used as a federal malpractice statute.”); *Bryan v. Rectors and Visitors of Univ. of Va.*, 95 F.3d 349, 351 (4th Cir. 1996) (stating that state malpractice law, rather than EMTALA, judges adequacy of care); *Collins v. DePaul Hosp.*, 963 F.2d 303, 307 (10th Cir. 1992) (denying “broad federal cause of action for negligence or malpractice in the emergency room.”); *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (disputing plaintiff's claim that EMTALA creates “sweeping federal cause of action” in malpractice or negligence); *Tank v. Chronister*, 941 F. Supp. 969, 972 (D. Kan. 1996) (holding statute never intended to be “federal malpractice statute”); *Hart v. Mazur*, 903 F. Supp. 277, 280 (D.R.I. 1995) (refusing to allow malpractice claims to be brought under EMTALA).

369. *See Pegram v. Herdrich*, 530 U.S. 211, 235 (2000) (cautioning against replicating state claims against HMOs at federal level).

natory medical decisions concluding that the plaintiff's real complaint is with the quality of medical care received and that such complaints are sound in state medical malpractice law and thus are not properly adjudicated under federal statutes.

Both facets of the courts' reluctance to apply federal civil rights laws to medical decisions also appear in the passive stance that federal regulators have adopted towards applying those laws to treatment decisions. The U.S. Commission on Civil Rights, as part of its 1999 report on health care disparities,³⁷⁰ reported on the policy development and rulemaking processes of DHHS's Office of Civil Rights (OCR) with respect to Title VI enforcement. One failing that the Commission noted was OCR's failure to articulate clearly what "discrimination" in the health care context means, particularly when it comes to determining what "equal access to quality health care" requires.³⁷¹ From the Commission's viewpoint, equal access requires that all Americans receive medical care of equal quality.³⁷² However, OCR's legal staff questioned both the agency's jurisdiction over denial of equal access claims and the agency's ability to assess the equality of access so defined, citing an inability to judge what appropriate care is.³⁷³ As the Commission reported: "Several staff noted the inability to obtain the medical expertise needed to challenge a [health care provider's] medically related rationale, suggesting the OCR was not equipped to make such determinations."³⁷⁴ Thus, the government agents charged with enforcing the civil rights laws in health care settings appear to share the courts' reluctance to get involved in cases alleging discrimination in medical treatment.

This reluctance may pose an insurmountable obstacle for a civil rights plaintiff alleging discriminatory medical treatment. A court that detects in her complaint (or her proof) an allegation that the plaintiff received inferior medical care may well send her packing to state court with instructions to file a malpractice claim, notwithstanding the plaintiff's central allegations of discriminatory treatment.³⁷⁵ Because of the improbability, discussed in Part IV, that medical malpractice law will provide many such

370. See HEALTH CARE CHALLENGE, *supra* note 7, at iii (documenting differences in treatment between white and black patients).

371. See *id.* Vol. II at 67-69 (referring to varying views among OCR staff members in definitions they give to "discrimination" as it appears in health care context).

372. See *id.* at 73-74 ("Discrimination occurs not only in the denial of services but also in the provision of inferior, inadequate, or inappropriate health care services or medical practices.").

373. See *id.* at 74 (discussing difficulty involved in expressing what exactly is meant by "appropriate care").

374. See *id.* (suggesting that OCR did not have sufficient grasp of medical procedure performed that would enable them to pursue discrimination case).

375. Of course, a court hearing a medical malpractice claim may also question whether it is simply a discrimination claim in disguise. See *Estate of Alcalde v. Deaton Specialty Hosp.*, 133 F. Supp. 2d 702, 710 n. 9 (D. Md. 2001) ("To the extent the [Rehabilitation] Act is the source of any such duty, however, then de-

plaintiffs with an avenue for redressing biased decisions, however, these instructions may leave a patient whose physician made biased treatment decisions without any legal recourse.

VI. RIDING THE CURRENTS

As stated earlier, a central purpose of this Article is to consider whether patients who have been the victims of biased medical decisions have an avenue for obtaining legal recourse. The analyses in the preceding two Parts suggest that those patients' prospects of obtaining a legal remedy through either a civil rights action or an action alleging breach of some professional duty are fairly bleak. Only those patients who fall within a class protected by a civil rights statute that arguably applies to medical decisions can even state a claim, and then they have to prove intentional discrimination on the part of the defendant physician. While victims of overtly biased decisions may thus be able to recover, most patients will have trouble proving intentional discrimination unless courts are willing to entertain the premise that discrimination fueled by subconscious bias can be deemed intentional. By contrast, an action based on the defendant physician's violation of some professional duty is theoretically open to all patients. As a practical matter, while medical malpractice and informed consent actions may allow patients to recover when bias leads to substandard treatment or disclosure, the thrust of those causes of action would be the physician's substandard care; physician bias is essentially irrelevant to liability. Although a claim alleging that biased medical decision making violated a doctor's fiduciary duty to her patients better tracks the wrong claimed, the law regarding physician liability for breach of fiduciary duty is fairly embryonic, as is the law regarding the availability of dignitary damages against physicians in the absence of physical injury. Thus, recovery on these grounds in any but the most blatant and egregious cases would require significant development in these areas.

The conclusion that existing law does not offer a clear avenue of redress for all patients who are the subjects of biased medical decisions, however, does not negate the importance of the potential for liability in these areas. Even if the practical challenges of proving discrimination and recovering dignitary damage prevent this Article's outlines for imposing liability for biased medical decisions from translating into actual recoveries for patients in a large number of cases, recognition of the mere potential for recovery has value. This Article's message is that whatever the number of biased medical decisions, the operation of bias—whether conscious or unconscious—is wrong and *may* be grounds for imposing liability. The near invisibility of the practice of biased medical decisions does not justify a tacit legal acceptance of those decisions. Whether biased medical decisions are common or rare, they present a problem that the law may play

defendants are correct in their argument that plaintiff has simply restated in professional malpractice verbiage her disparate treatment claim under the Act.”).

some role in addressing—even if only by calling medicine’s attention to the immediacy of the problem for individual doctors.

In the short run, the most effective role of law in addressing bias in clinical decision making may lie precisely in flagging doctors’ attention to the need to scrutinize their own decision-making processes more carefully to screen out any biases. Many of the editorial comments in the medical literature on treatment disparities call for self-reflection by physicians as they make medical decisions. In 1990, the AMA’s Council on Ethical and Judicial Affairs called on physicians to “examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment.”³⁷⁶ Perhaps a few legal judgments against doctors for biased decisions, even if in the more egregious cases, might add significant force to these aspirational statements. Although some research raises questions about the ability of individuals to identify and counteract the subconscious biases that infect their decisions,³⁷⁷ other research indicates that persons who seek to act fairly may be able to counteract the influence of unconscious bias on their decisions.³⁷⁸ Thus, physicians’ awareness of the mere potential for legal liability might serve to ignite their willingness to spend the time and emotional energy required to examine their own decision-making processes with an eye to detecting possible biases. In the long run, if this (admittedly optimistic) forecast comes to pass, then the development of a more thorough-going and inclusive system of liability for biased medical decisions may seem less necessary.

This Article has focused on surveying the evidence of biased medical decisions and identifying possible legal responses to those decisions, as well as the shortcomings of those responses under current law. Notwithstanding the conclusion that existing law will only rarely offer any effective remedy to a patient who is the victim of a biased medical judgment, some signs of hope—both for improving patients’ remedial prospects and for reducing the role that physician bias plays in medical decisions—can be found in currents already flowing in the areas of civil rights enforcement and medical quality improvement. A brief consideration of how these currents might feed into efforts both to hold doctors legally accountable for their biased decisions and to decrease the incidence of biased medical decisions follows.

First, policy makers and commentators have already issued calls for more aggressive enforcement of civil rights laws in response to evidence of

376. See *Black-White Disparities*, *supra* note 35, at 2346 (encouraging doctors to examine their own practice); see also Geiger, *supra* note 48, at 816 (“The answers we need are to questions that are at a more personal level.”); Freeman & Payne, *supra* note 93, at 1046 (“Physicians . . . must learn to see people not through the lens of race but instead as the individual persons they are.”).

377. See Wax, *supra* note 165, at 1158 (“Research in cognitive psychology suggests that biases in judgment stemming from categorical generalizations cannot be reliably manipulated or controlled . . . by the person harboring those biases . . .”).

378. See Chamallas, *supra* note 241, at 805-06 (describing “prejudice [as] hard, but not impossible, to break”).

racial and ethnic disparities in medical care. One action sought is for the federal government to articulate standards for what constitutes discrimination in the context of health care treatment.³⁷⁹ In addition, a common refrain that is gathering volume is the need for federal agencies to begin collecting data regarding the provision of medical services to members of racial and ethnic minorities in order to permit assessment of compliance with those standards. Numerous commentators have emphasized the crucial role of collecting and reporting data that track patient race in enhancing Title VI enforcement efforts.³⁸⁰ Likewise, a recently issued report commissioned by the Commonwealth Fund concludes that DHHS must assume a leadership role in mandating the collection and reporting of racial and ethnic data by all programs supported by departmental funds.³⁸¹ This sound and fury over the importance of data collection might well signify nothing, however, were it not to capture the attention of policymakers who have authority to compel the data collection. It did so in 2000, when Congress enacted the Minority Health and Health Disparities Research and Education Act. Among this Act's provisions is a charge to the National Academy of Sciences to study DHHS's existing data collection and reporting systems and practices and to report to Congress on what data is needed to support an effective response to racial and ethnic disparities.³⁸² Although this report was not submitted by the Act's November 2001 deadline, it is expected to recommend a data collection system for DHHS.³⁸³

A commonly articulated purpose for proposed data collection efforts is to enable DHHS to carry out its administrative responsibility of enforcing Title VI. Certainly, data regarding racial and ethnic disparities in the provision of services by particular providers would enable the agency's Office of Civil Rights to target those providers for enforcement action. Pub-

379. See HEALTH CARE CHALLENGE, *supra* note 7 at 67-69 (discussing attempt on part of government to quantify what is meant by health care discrimination); Rosenbaum et al., *supra* note 260, at 254 (arguing that standards should be set in area of health care).

380. See, e.g., Bowser, *supra* note 8, at 126 ("If we are serious about invigorating Title VI enforcement, the cornerstone is the systematic collection of data from each health care provider that receives federal funds on racial disparities in the use of services and the choices of diagnostic and therapeutic alternatives."); Smith, *supra* note 255, at 326 (emphasizing need for "external monitoring of process and outcomes"); Watson, *supra* note 13, at 222 (encouraging reporting of patient data by race).

381. See RUTH T. PEROT & MARA YOUDELMAN, RACIAL, ETHNIC, AND PRIMARY LANGUAGE DATA COLLECTION IN THE HEALTH CARE SYSTEM: AN ASSESSMENT OF FEDERAL POLICIES AND PRACTICES 24 (2001) (espousing idea that DHHS must adopt such role).

382. See Minority Health and Health Disparities Research and Education Act of 2000, Title III, Data Collection Relating to Race and Ethnicity, § 301(b)(3), Pub. L. No. 106-525, 114 Stat. 2495 (2000) (amending Public Health Service Act "to improve health of" minorities).

383. See Watson, *supra* note 13, at 223 (predicting that "report will recommend a data collection system").

lic availability of this data, however, would also enable both quasi-governmental entities such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and private bodies to use the information in their certification and purchasing decisions. Within the past year, groups both of health plans and of major self-insuring employers have announced plans to establish incentive systems that will financially reward providers who meet certain quality standards.³⁸⁴ If provider-specific data regarding health services provided to racial and ethnic minorities becomes available, groups of private insurers or health care purchasers will similarly be able to establish financial incentives for providers to reduce disparities in care.³⁸⁵

Moreover, the public availability of such data could ease significantly the burden for some plaintiffs attempting to prove racially biased medical decisions in civil rights actions. Although data showing race-based disparities in a physician's prescription of a specific treatment does not directly prove that the physician's treatment decision was biased by a particular patient's race, it can provide circumstantial evidence of bias from which discrimination against the plaintiff may be inferred.³⁸⁶ The difficulty and expense in collecting such data currently erects a major obstacle for plaintiffs considering a private Title VI action against a health care provider; that obstacle could be eliminated by the governmental collection and reporting of data.

Finally, the reporting of provider-specific data regarding racial and ethnic disparities could prove a potent tool in drawing physicians' attention to hitherto unrecognized patterns in their own clinical decisions. If most physician bias that operates today is indeed subconscious, then most physicians who make biased decisions do not perceive their own biases. Presenting a cardiologist with data showing, for example, that she has ordered bypass surgery significantly more often for her white patients than for her black patients may motivate her to probe more consciously how she makes decisions between surgical and non-surgical interventions. And if a good faith desire to promote patient welfare doesn't sufficiently motivate physician self-reflection, concern regarding the potential for adverse action by a federal agency, private health plans and individual patients

384. See Milt Freudenheim, *Companies Start Fund to Reward Hospitals for Better Care*, N.Y. TIMES, Oct. 18, 2001, at C3 (reporting on \$2 million incentive program established by four major New York employers to improve hospitals' patient safety records); Press Release, Integrated Healthcare Ass'n, *California Health Plans Announce First Statewide, Multi-plan Initiative to Reward Physician Groups for Quality Care* (Jan. 15, 2002), at <http://www.iha.org/011502.htm> (announcing new "Pay for Performance" initiative).

385. Accord Watson, *supra* note 13, at 223 (suggesting that "group purchasers, both public and private, should provide financial incentives in the form of performance standards to encourage institutions and health care professionals to meet these goals [for reducing race-based disparities]"); cf. Fiscella, *supra* note 43, at 2581 (suggesting ways to make health plans "accountable to purchasers, accreditation agencies, and consumers for addressing disparities among their members").

386. For further discussion, see *supra* note 327 and accompanying text.

may add the necessary encouragement. Thus, increased federal data collection and reporting may serve not only to enable more vigorous administrative enforcement of civil rights laws, but may also support both patients' private remedial actions and physicians' efforts at self-policing.

A second current that is gaining momentum within the medical community may also feed into efforts to reduce the incidence of biased medical decisions. The past several years have witnessed skyrocketing public attention to issues of health care quality,³⁸⁷ and a variety of proposed approaches to improving the quality of patient care have issued forth.³⁸⁸ In addition to increased use of "report cards" that contain provider-specific quality information that can be used by large purchasers of health care services, another approach to improving quality is the push for evidence-based medicine. This movement seeks "to evaluate the safety, effectiveness, and cost of medical practices using tools from science and social science and to base clinical practice on such knowledge."³⁸⁹ In short, evidence-based medicine emphasizes medicine's nature as a science, rather than an art.

The movement towards evidence-based medicine figures prominently in a recent report issued by a committee of the Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*.³⁹⁰ The authors of the report undertake no less daunting a task than proposing an "agenda for redesigning the 21st-century health care system."³⁹¹ Notably, two of the six aims that the authors articulate for 21st-century health care are that it should be both effective ("providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit") and equitable ("providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status").³⁹²

The Institute of Medicine report highlights a decrease in practice variations³⁹³ as one desired outcome of a move towards scientifically grounded clinical practice. For if patients receive care based on the best existing medical science, then "[c]are should not vary illogically from clinician to clinician or from place to place."³⁹⁴ Rather than leaving treat-

387. See Elise C. Becher & Mark R. Chassin, *Improving the Quality of Health Care: Who Will Lead?*, 20 HEALTH AFF. 164, 165 (2001) (stating that "[a]n intense public debate about health care quality ignited in 1999").

388. See generally Grol, *supra* note 14 (summarizing various approaches).

389. See Marc A. Rodwin, *The Politics of Evidence-Based Medicine*, 26 J. HEALTH POL. POL'Y & LAW 439, 441-43 (2001) (defining evidence-based medicine movement).

390. CROSSING THE QUALITY CHASM, *supra* note 17.

391. See *id.* at 5 (proposing changes in health care system).

392. See *id.* at 6 (proposing goals for improvement of health care system).

393. For a discussion of practice variations, see *supra* notes 18-19 and accompanying text.

394. See CROSSING THE QUALITY CHASM, *supra* note 17, at 8 (recommending health care processes be redesigned to include evidence-based decision making).

ment decisions to the influence of local practice styles or a physician's personal experience or training, proponents of evidence-based medicine assert that incorporating scientific evidence into widely disseminated clinical practice guidelines will give individual practitioners the ability to practice evidence-based medicine. The central purpose of clinical practice guidelines, which may be issued by professional medical societies, government bodies or health care payers, is to inform physicians about what treatment is appropriate for a specific medical condition or constellation of symptoms.³⁹⁵

The connection between using evidence-based medicine to improve the quality of patient care and using evidence-based medicine to decrease the incidence of biased medical decisions is straightforward. As discussed in Part II, disparities in the medical services rendered to different patient groups are particularly likely when the treatment for a particular condition is discretionary, i.e., when it is not clear what treatment is appropriate for the condition. Through the development of guidelines incorporating the best available scientific evidence, however, the number of conditions for which the choice of treatment is discretionary is reduced, and thus the opportunities for bias to influence the choice of treatment are similarly decreased. Concededly, because it is impossible for clinical guidelines to account for and address all the possible variations in the clinical details of specific patients, clinical guidelines will never entirely eliminate physician discretion. Commentators have also raised concerns about the quality of some guidelines and the ability of developers to keep practice guidelines current with advances in scientific knowledge.³⁹⁶ Nonetheless, a systematic effort to replace physician discretion with science-based guidelines seems likely to shrink many existing disparities.

Moreover, in contrast to efforts to increase data collection regarding racial disparities in order to invigorate civil rights enforcement activities, efforts to promote evidence-based medicine—if they deliver on their supporters' claims—stand to decrease the operation of all types of bias, as well as to improve the quality of patient care generally. Thus, its proponents might characterize evidence-based medicine as a rising tide that raises all (patients') ships.³⁹⁷ While riding the civil rights current promoting in-

395. See Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PA. L. REV. 645, 647 (2001) (defining clinical practice guidelines).

396. See George P. Browman, *Development and Aftercare of Clinical Guidelines: The Balance between Rigor and Pragmatism*, 286 JAMA 2584 (2001); Grol, *supra* note 14, at 2580.

397. In addition, in some cases courts may allow a patient suing his doctor for malpractice to admit evidence of a clinical practice guideline as helping to establish the prevailing standard of care. Thus, if a patient alleges that bias caused her doctor to deviate from the treatment called for by a guideline, the deviation alone may be grounds for imposing liability, regardless of the patient's ability to prove bias. As discussed in Part V *supra*, however, recovery in that instance would be based on the provision of substandard care, not on the operation of bias. For an argument for restricting both patients' inculpatory uses and physicians' exculpa-

creased data collection may allow targeted attacks on racially and ethnically biased medical decisions, riding the evidence-based medicine current may enable a broader assault on suboptimal care generally.

Fortunately, these two contrasting approaches do not appear to be incompatible. Although it has been argued, in the context of the development of informed consent doctrine, that increasing physicians' potential legal exposure to patients ultimately works to the detriment of patients by diminishing the level of trust in a patient-physician encounter, a recognition of a physician's legal accountability for biased decisions seems unlikely to produce such results. Rather than motivating physicians to replace real conversation with a legal form entitled "informed consent," the existence of a "discriminatory medical decision" cause of action under civil rights statutes should motivate doctors to identify relevant clinical information about their individual patients and to elicit those patients' actual preferences, rather than employing group-based stereotypes. Of course, as Sidney Watson astutely points out, a civil rights enforcement approach to health care disparities focuses—perhaps counterproductively—on backwards-looking "blaming and sanctioning"³⁹⁸ rather than on moving forward to design systems that maximize the likelihood that patients will receive unbiased advice.

And perhaps, as the project of considering how best to decrease the incidence of biased decisions continues beyond this Article, we may conclude that holding physicians legally liable for the operation of bias that occurs on a subconscious level is not productive. On the other hand, we may conclude that holding physicians to a high standard of screening their own decisional processes to prevent any "negligent discrimination" is appropriate. What is clear is that current discussions of race-based data collection and the role of evidence-based medicine provide fertile ground for further exploring potential solutions to the problem of biased medical decision making.

VII. CONCLUSION

Published studies suggest that bias based on a clinically irrelevant characteristic of a patient at times influences some physicians' medical judgments. These biased medical decisions can have adverse impacts on the particular patient who is the victim of the biased decision, as well as on the public's health more broadly. It is questionable, however, whether either existing civil rights laws or professional liability actions provide victims of biased medical decisions with an avenue for obtaining effective legal redress. Civil rights approaches fail to deal with the full spectrum of

tory uses of practice guidelines in malpractice litigation, *see* Mello, *supra* note 395, at 677-710 (discussing various uses of clinical practice guidelines for both patients and physicians).

398. *See* Watson, *supra* note 13, at 219 (noting civil rights approaches are reactive—not proactive—thus not final solutions).

biased medical decisions and leave plaintiffs struggling to convince courts that subconscious bias can produce intentional discrimination. Professional liability approaches, by contrast, seem uncomfortable scrutinizing the physician's subjective motivation for treatment choices and typically demand concrete physical injuries as a predicate for patient recovery. While existing legal frameworks do not provide ready remedies for victims of physician bias, developments in the areas of civil rights enforcement and medical quality improvement may support future efforts to respond to the problem of physician bias.

