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ELIMINATING RACIAL DISCRIMINATION IN HEALTH CARE: A CALL FOR STATE HEALTH CARE ANTI-DISCRIMINATION LAW

Vernellia R. Randall, JD, MSN

“It might be that civil rights laws often go unenforced; it might be that current inequities spring from past prejudice and long standing economic differences that are not entirely reachable by law; or it might be that the law sometimes fails to reflect, and consequently fails to correct, the barriers faced by people of color.”

--Derrick Bell¹

Equal access to quality health care is a crucial issue facing the United States (“US”).² For too long, we have denied too many Americans equal access to quality health care based on race, ethnicity, and gender.³ Many factors contribute to inequities: cultural incompetence of health care providers, socioeconomic inequities, disparate impact of facially neutral practices and policies, inadequacy of civil rights laws and enforcement, and multiple forms of discrimination. These inequities exist in health status, access to health care services, participation in health research and

¹ DERRICK A. BELL, JR., AND WE ARE NOT SAVED: THE ELUSIVE QUEST FOR RACIAL JUSTICE 52 (Basic Books 1987) [hereinafter NOT SAVED].

² See, e.g., COMMITTEE ON UNDERSTANDING AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2002), available at <http://www.iom.edu/?id=16740> (last visited June 26, 2002) [hereinafter IOM REPORT]; see also THE UNITED STATES COMMISSION ON CIVIL RIGHTS, THE HEALTH CARE CHALLENGE: ACKNOWLEDGING DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY, THE ROLE OF GOVERNMENTAL AND PRIVATE HEALTH CARE PROGRAMS AND INITIATIVES (Sept. 1999), available at <http://www.law.umaryland.edu/marshall/usccr/documents/cr12h34z.pdf> (last visited June 26, 2002) [hereinafter U.S. COMMISSION ON CIVIL RIGHTS I].

³ See, e.g., W. MICHAEL BYRD AND LINDA A. CLAYTON, AN AMERICAN HEALTH DILEMMA: A MEDICAL HISTORY OF AFRICAN AMERICANS AND THE PROBLEM OF RACE, BEGINNINGS TO 1900 (Routledge 2000) [hereinafter AN AMERICAN HEALTH DILEMMA I]; W. MICHAEL BYRD AND LINDA A. CLAYTON, AN AMERICAN HEALTH DILEMMA: A MEDICAL HISTORY OF AFRICAN AMERICANS AND THE PROBLEM OF RACE, 1900 TO PRESENT (Routledge 2002) [hereinafter AN AMERICAN HEALTH DILEMMA II]; see also U.S. COMMISSION ON CIVIL RIGHTS I, *supra* note 2.

receipt of health care financing.⁴ This inequity in health care is doubly significant given the devastating racial inequity in health status that exists. The combination of racial inequity in health status, institutional racism in health care and inadequate legal protection points to a need for a major civil rights law for health care.

I. INEQUITY IN HEALTH STATUS: BRIEF REVIEW

The need to focus specific attention on the discrimination inherent in the institutions and structures of health care is overwhelming. Racial minorities are sicker than white Americans; they are dying at a significantly higher rate. These are undisputed facts. Many examples of inequities in health status between racial/ethnic groups exist: infant mortality rates are 2½ times higher for blacks,⁵ and 1½ times higher for American Indians, than for whites;⁶ the death rate for heart disease for blacks is higher than for whites;⁷ 50 percent of all AIDS cases are among minorities who account for only 25 percent of the U.S. population;⁸ the prevalence of diabetes is 70 percent higher among blacks and twice as high among Hispanics as among whites;⁹ Asian Americans and Pacific Islanders have the highest rate of tuberculosis of any racial/ethnic group;¹⁰ cervical cancer is nearly five times more likely among Vietnamese American women than white women;¹¹ women are less likely than men to receive lifesaving drugs for heart attacks;¹² more women than men require bypass surgery or suffer a heart attack after an angioplasty.¹³

Yet, despite these significant health status inequities, we have denied many Americans equal access to quality health care based on race, ethnicity, and gender. Factors that contribute to this inequity in health care include the following: cultural incompetence of health care providers, socioeconomic inequities, disparate impact of facially neutral practices

⁴ See, e.g., U.S. COMMISSION ON CIVIL RIGHTS I, *supra* note 2; see also 2 THE UNITED STATES COMMISSION ON CIVIL RIGHTS, ACKNOWLEDGING DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY, THE ROLE OF FEDERAL CIVIL RIGHTS ENFORCEMENT (1999) [hereinafter U.S. COMMISSION ON CIVIL RIGHTS II].

⁵ U.S. COMMISSION ON CIVIL RIGHTS I, *supra* note 2, at 11.

⁶ *Id.*

⁷ *Id.* (147 deaths per 100,000 for blacks compared to 105 deaths per 100,000 for whites).

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.* at 31.

¹¹ *Id.*

¹² *Id.* at 14-15.

¹³ *Id.*

and policies, misunderstanding of civil rights laws, and discrimination contribute to inequities in health status, access to health care services, participation in health research, and receipt of health care financing.

Drs. Michael Byrd and Linda Clayton clearly laid out the long history of racism and medicine in their seminal work: "An American Dilemma: A Medical History of African Americans and the Problem of Race, Beginnings to 1900" and "An American Dilemma: A Medical History of African Americans and the Problem of Race, 1900 to 2000." In their work, Drs. Byrd and Clayton show that the problem of black health status and black health care access is a part of a long continuum of racism and racial discrimination dating back almost 400 years. In fact, since colonial times, the racial dilemma that affected America also distorted medical relationships and institutions.¹⁴ Throughout our history, we have actively assigned racial minorities to the underfunded, overcrowded, inferior, public health care sector.¹⁵

Historically, medical doctors and medical leadership helped to establish and maintain a racially discriminatory health care system. They helped to establish the slaveocracy, create the racial inferiority myths, build a segregated health subsystem, and maintain racial bias in the diagnosis and treatment of patients.¹⁶ Only after 350 years of active discrimination and neglect, were efforts made to admit minorities into the "mainstream" health system.¹⁷ However, these efforts were flawed and since 1975 minority health status has steadily eroded. Consequently, minorities continue to experience racial discrimination in access to health care and quality of health care received.¹⁸

Yet, current issues in health inequities are not isolated to problems in the health system. They are the cumulative result of both past and current racism throughout US culture. For instance, because of institutional racism, minorities have less education and fewer educational opportunities.¹⁹ Minorities are disproportionately homeless and have

¹⁴ AN AMERICAN HEALTH DILEMMA I, *supra* note 3; AN AMERICAN HEALTH DILEMMA II, *supra* note 3.

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ AN AMERICAN HEALTH DILEMMA II, *supra* note 3.

¹⁸ *Id.*

¹⁹ In 1993, the high school dropout rate for blacks was 12.6 and 28.6 for Hispanics compared to 7.3 for whites. NATIONAL CENTER FOR EDUCATION STATISTICS, U.S. DEPARTMENT OF EDUCATION, DIGEST OF EDUCATION STATISTICS Table 106 (2000), available at <http://nces.ed.gov/programs/digest/d00/dt106.asp> (last visited June 26, 2002); see also REBECCA GORDON, LIBERO DELLA PIANA & TERRY KELEHER, FACING THE CONSEQUENCES: AN EXAMINATION OF RACIAL DISCRIMINATION IN U.S. PUBLIC

poorer housing options.²⁰ Due to discrimination and limited educational opportunities, minorities disproportionately work in low pay, high health risk occupations (e.g., migrant farm workers, fast food workers, garment industry workers).²¹ Historic and present racism in land and planning policy also plays a critical role in minority health status.²² Minorities are much more likely to have toxic materials (and other unhealthy uses) sited in their communities than whites despite income.²³ For example, over-concentration of alcohol and tobacco outlets and the legal and illegal dumping of pollutants pose serious health risks to minorities.²⁴ Exposure to these risks is not a matter of individual control or even individual choice. It is a direct result of discriminatory policies designed to protect white privilege at the expense of minority health.

SCHOOLS (2000), available at <http://www.arc.org/content/view/293/36/> (last visited June 26, 2002); THE PERSISTENCE OF WHITE PRIVILEGE AND INSTITUTIONAL RACISM IN UNITED STATES POLICY, TRANSNATIONAL RACIAL JUSTICE INITIATIVE SHADOW REPORT CERD 38-41 (2001), available at http://www.thepraxisproject.org/tools/White_Privelege.pdf (last visited June 26, 2002) [Hereinafter "The White Privilege Shadow Report"]; U.S. COMMISSION ON CIVIL RIGHTS I, *supra* note 2, at 15-18.

²⁰ Home ownership among Hispanics nationally stands at 47.3 percent and at 47.7 percent for African-Americans, compared to 74.3 percent for the white, non-Hispanic. See, e.g., Deborah Kenn, *Institutionalized, Legal Racism: Housing Segregation And Beyond*, 11 B.U. PUB. INT. L.J. 35 (2001); The White Privilege Shadow Report, *supra* note 19, at 46-71. 40% of homeless clients served were minorities. See HUD USER, HOMELESSNESS: PROGRAMS AND THE PEOPLE THEY SERVE-TECHNICAL REPORT (1999), available at http://www.huduser.org/publications/homeless/homeless_tech.html (last visited June 26, 2002); see also All Other Things Being Equal: A Paired Testing Study of Mortgage Lending Institutions 48 (April 2002) (finding that African American and Hispanic home buyers in both Los Angeles and Chicago face a significant risk of unequal treatment when they visit mainstream mortgage lending institutions to make pre-application inquiries); U.S. COMMISSION ON CIVIL RIGHTS I, *supra* note 2, at 15-18.

²¹ BUREAU OF LABOR STATISTICS, NUMBER OF NONFATAL OCCUPATIONAL INJURIES AND ILLNESSES INVOLVING DAYS AWAY FROM WORK BY INDUSTRY AND RACE OR ETHNIC ORIGIN OF WORKER (2000), <http://www.bls.gov/iif/oshwc/osh/case/ostb1071.txt> (last visited June 26, 2002); see also U.S. COMMISSION ON CIVIL RIGHTS I, *supra* note 2, at 18.

²² See, e.g., The White Privilege Shadow Report, *supra* note 19, at 54-71; see also DOUGLAS S. MASSEY AND NANCY A. DENTON, *AMERICAN APARTHEID: SEGREGATION AND THE MAKING OF THE UNDERCLASS* 36 (Harvard Univ. Press 1993).

²³ See, e.g., Jill E. Evans, *Challenging The Racism in Environmental Racism: Redefining The Concept of Intent*, 40 ARIZ. L. REV. 1219 (1998); see also U.S. COMMISSION ON CIVIL RIGHTS I, *supra* note 2, at 18-20.

²⁴ See, e.g., Vernellia Randall, *Smoking, the African-American Community, and the Proposed National Tobacco Settlement*, 29 U. TOL. L. REV. 677 (1998); see also Kathryn A. Kelly, *The Target Marketing of Alcohol and Tobacco Billboards to Minority Communities*, 5 U. FLA. J.L. & PUB. POL'Y 33 (1992).

II. INEQUITY IN HEALTH CARE: A BRIEF REVIEW

Compounding the racial discrimination experienced generally, is the institutional racism in health care that affects access to health care and the quality of health care received.²⁵ Despite efforts to eliminate discrimination and reduce racial segregation over the past thirty years, little change in the quality of or access to health care for many minorities has occurred. According to the US Commission on Civil Rights:

“Despite the existence of civil rights legislation equal treatment and equal access are not a reality for racial/ethnic minorities and women in the current climate of the health care industry. Many barriers limit both the quality of health care and utilization for these groups, including . . . discrimination.”²⁶

Racial discrimination in health care delivery, financing, and research continues to exist, and racial barriers to quality health care manifests themselves in many ways including: lack of economic access to health care,²⁷ barriers to hospitals and health care institutions,²⁸ barriers to

²⁵ See, e.g., Marianne Engelman Lado, *Unfinished Agenda: the Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery*, 6 TEX. F. ON C.L. & C.R. (2001); see also René Bowser, *Racial Profiling in Health Care: an Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79 (2001) [hereinafter *Racial Profiling*]; 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 (1996) [hereinafter *Slavery, Segregation and Racism*]; Vernellia R. Randall, *Racist Health Care: Reforming an Unjust Health Care System to Meet the Needs of African-Americans*, 3 HEALTH MATRIX 127 (1993) [hereinafter *Racist Health Care*].

²⁶ U.S. COMMISSION ON CIVIL RIGHTS I, *supra* note 2, at 202.

²⁷ More than 43 million Americans are uninsured with no economic access to health care. A disproportionate number of the uninsured are racial minorities. As access to health insurance in the United States is most often tied to employment, racial stratification of the economy due to other forms of discrimination has resulted in a concentration of racial minorities in low wage jobs. These jobs are almost always without insurance benefits. As a result, disproportionate numbers of the uninsured are racial minorities. In fact, a disproportionate number of racial minorities have no insurance, are unemployed, and are employed in jobs that do not provide health care insurance, disqualify for government assistance programs, or fail to participate because of administrative barriers. Gaps in health status, and the absence of relevant health information, are directly related to access to health care.

²⁸ The institutional/structural racism that exists in hospitals and health care institutions

physicians and other providers,²⁹ racial discrimination in medical treatment,³⁰ discriminatory policies and practices,³¹ lack of language and culturally competent care,³² disparate impact of the intersection of race

manifests itself in the (1) adoption, administration, and implementation of policies that restrict admission; (2) the closure, relocation or privatization of hospitals that primarily serve the minority community; and (3) the continued transfer of unwanted patients (known as "patient dumping") by hospitals and institutions. Such practices have a disproportionate effect on racial minorities banishing them to distinctly substandard institutions or to no care at all.

²⁹ Areas that are heavily populated by minorities tend to be medically under-served. Disproportionately few White physicians have their practices located in minority communities. Minority physicians are significantly more likely to practice in minority communities, making the education and training of minorities extremely important. Yet, due to discrimination in postsecondary education, racial biases in testing and quality of life issues affecting school performance, minorities are seriously under represented in health care professions. The shortage of minority professionals affects not only access to health care but also access to the power and resources to structure the health care system leaving its control almost exclusively in white hands. The result is an inadequate, ineffective and marginalized voice on minority health care issues.

³⁰ Differences in health status reflect, to a large degree, inequities in preventive care and treatment. For instance, African Americans are more likely to require health care services, but are less likely to receive them. Disparity in treatment has been well documented in a number of studies including studies done on AIDS, cardiology, cardiac surgery, kidney disease, organ transplantation, internal medicine, obstetrics, prescription drugs, treatment for mental illness, pain treatment and hospital care. *See, e.g., U.S. Slavery, Segregation and Racism, supra note 25; see also Randall, Racist Health Care, supra note 25.*

³¹ Discriminatory policies and practices can take the form of medical redlining, excessive wait times, unequal access to emergency care, deposit requirements as a prerequisite to care, and lack of continuity of care, which all have a negative effect on the type of care received. *See, e.g., U.S. COMMISSION ON CIVIL RIGHTS I, supra note 2, at 74-78; see also Sidney Watson, Reinvigorating Title VI: Defending Health Care Discrimination - It Shouldn't be so Easy, 58 FORDHAM L. REV. 939 (1990).*

³² A key challenge has been to get the Government to establish clear standards for culturally competent health care. Culturally competent care is defined as care that is "sensitive to issues related to culture, race, gender, and sexual orientation." Vernellia Randall, *Does Clinton's Health Care Reform Proposal Ensure [E]Qual[ity] of Health Care for Ethnic Americans and the Poor?* 60 BROOK. L. REV. 167, 205-12 (1994). Cultural competency involves ensuring that all health care providers can function effectively in a culturally diverse setting; it involves understanding and respecting cultural differences. In addition to recognizing the disparities in health status between White Americans and minority groups, we must recognize differences within groups as well. Ethnic and racial minority communities include diverse groups with diverse histories, languages, cultures, religions, beliefs, and traditions. This diversity is reflected in the health care they receive and the experiences they have with the health care industry. Without understanding and incorporating these differences, health care cannot be provided in a culturally competent manner. *See, e.g., U.S. COMMISSION ON CIVIL RIGHTS I, supra note 2, at 52-54.*

and gender,³³ inadequate inclusion in health care research,³⁴ and rationing through managed care.³⁵

³³ The unique experiences of women of color have been largely ignored by the health care system. These women share many of the problems experienced by minority groups, in general, and women, as a whole. However, race discrimination and sex discrimination often intersect to magnify the difficulties minority women face in gaining equal access to quality health care. In addition to barriers restricting access to health care for racial/ethnic minorities, there are barriers to care that predominantly affect minority women. There are also gender differences in medical use, provision of treatments, and inclusion in research. This is partly the result of different expectations of medical care between men and women and of gender bias of health care providers. *See, e.g.,* U.S. COMMISSION ON CIVIL RIGHTS I, *supra* note 2, at 47-50; *see also* Lisa C. Ikemoto, *The Fuzzy Logic of Race and Gender in the Mismeasure of Asian American Women's Health Needs*, 12. 65 U. CIN. L. REV. 799 (1997); Diane E. Hoffmann and Anita J. Tarzian, *The Girl Who Cried Pain: a Bias Against Women in the Treatment of Pain*, 29 J.L. MED. & ETHICS 13 (2001); Michelle Oberman and Margie Schaps, *Women's Health and Managed Care*, 65 TENN. L. REV. 555 (1998); 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 (1995).

³⁴ Despite volumes of literature suggesting the importance of race, ethnicity, and culture in health, health care, and treatment, there is relatively little information available on the racial, ethnic, and biological differences that affect the manifestations of certain illnesses and their treatments. In response to years of exclusion of minorities and women, several statutory requirements have been enacted to ensure that research protocols include a diverse population. The health condition of women and minorities will continue to suffer until they are included in all types of health research. *See, e.g.,* U.S. COMMISSION ON CIVIL RIGHTS I, *supra* note 2, at 109-117, Pub. L. No. 103-43, 107 Stat. 122 (codified in scattered sections of 8 and 42 U.S.C. (1994 & Sup II 1996)).

³⁵ The health care financing system has been steadily moving to managed care as a means of rationing health care. Without proper oversight, oversight that does not currently exist, managed care will, over time, tend to place increasingly stringent requirements on providers. They may fail to develop more expensive but culturally appropriate treatment modalities, and they may refuse or minimize the expenditures necessary to develop adequate infrastructure for minority communities. The potential for discrimination, particularly racial/ethnic discrimination to occur in the context of managed care is significant and is recognized as such by OCR and leading commentators and advocates for civil rights in health care services, financing, and treatment. However, little has been to protect minorities from this risk of discrimination. *See, e.g.,* Vernellia R. Randall, *Impact of Managed Care Organizations on Ethnic Americans and Under Served Populations*, 5 J. HEALTH CARE FOR THE POOR UNDERSERVED 224 (1994); Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 3 (1994).

III. INADEQUACY OF FEDERAL ANTI-DISCRIMINATION PROTECTION

Several federal laws address access to health care: Title XVIII (Medicare)³⁶ and Title XIX (Medicaid)³⁷ of the Social Security Act, Title IX,³⁸ and the Hill Burton Act.³⁹ The only federal law related to eliminating racial discrimination in health care delivery is Title VI of the Civil Rights Act.⁴⁰

Racial inequality in health care persists in the United States despite laws against racial discrimination, in significant part because of the inadequacy of Title VI.⁴¹ On its face, Title VI (with its implementing regulations) should be an effective tool for eliminating racial discrimination. The Civil Rights Act of 1964 provides the legal force for desegregation efforts in health care.⁴² Specifically, Section 601 of Title VI provides: "No person in the United States, shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving federal financial assistance."⁴³

In short, Title VI appears to prohibit discrimination of all kinds. Still, nothing in anti-discrimination law is as simple as it might appear. While, several problems are that make Title VI and ineffective tool, among the most significant is the interpretation by the Supreme Court that Title VI only addresses intentional discrimination only. Further,

³⁶ Social Security Amendments, Pub. L. No. 89-97, Titles XVIII, 79 Stat. 286 (1965) (the act does not contain any general anti-discrimination clauses although the implementing regulations require providers and facilities to abide by Title VI).

³⁷ *Id.*

³⁸ 20 U.S.C. §§ 1681-88 (2002) (limited to sex discrimination in educational programs).

³⁹ 42 U.S.C. §§ 291a-291(o) (2002) (requires uncompensated care and community service by facilities that receive funding under Hill-Burton Acts).

⁴⁰ See, e.g., DAVID BARTON SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION* (Univ. of Michigan Press 1999) [hereinafter *HEALTH CARE DIVIDED*]; see also David Barton Smith, *Addressing Racial Inequities In Health Care: Civil Rights Monitoring And Report Cards*, 23 J. HEALTH POL. POL'Y & L. 75 (1998); Randall, *Racist Health Care*, *supra* note 25.

⁴¹ See, e.g., Barbara Noah, *Racial Disparities in the Delivery of Health Care?*, 35 SAN DIEGO L. REV. 135 (1998); see also Daniel K. Hampton, *Title VI Challenges by Private Parties to the Location of Health Care Facilities: Toward a Just and Effective Action*, 37 B.C. L. REV. 517 (1996); Marianne L. Engelman Lado, *Breaking the Barriers of Access to Health Care: a Discussion of the Role of Civil Rights Litigation and the Relationship Between Burdens of Proof and the Experience of Denial*, 60 BROOK. L. REV. 239 (1994).

⁴² Title VI of the 1964 Civil Rights Act, Pub. L. No. 88-352, 78 Stat. 252 (1964) (codified at 42 U.S.C. § 2000d-2000d-4 (2005)).

⁴³ *Id.*

regulatory agencies have interpreted Title VI to exclude physicians in private practice.

Unfortunately, the Supreme Court has held in *Alexander v. Choate*⁴⁴ that Title VI itself directly reached only instances of intentional discrimination; included in the definition is subtle discrimination. Subtle discrimination⁴⁵ is generally considered intentional based on large part on micro-aggressions⁴⁶ with the primary difference being the reliance on circumstantial evidence to improve intent.⁴⁷ However, the reliance on intent, subtle or direct, is particularly problematic for health care where most discrimination is either disparate impact discrimination or “unthinking or unconscious.”⁴⁸

[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

⁴⁴ *Alexander v. Choate*, 469 U.S. 287 (1985).

⁴⁵ See, e.g., Terry Smith, *Everyday Indignities: Race, Retaliation and the Promise of Title VII*, 34 COLUM. HUM. RTS. L. REV. 529 (2003); cf. *Lynn v. Regents of Univ. of California*, 656 F.2d 1337, 1343 n.5 (9th Cir. 1981). In *Lynn v. Regents*, the court said: “We are saying only what Title VII commands: when plaintiffs establish that decisions regarding academic employment are motivated by discriminatory attitudes relating to race or sex, or are rooted in concepts which reflect such discriminatory attitudes, however subtly, courts are obligated to afford the relief provided by Title VII.” *Id.*

⁴⁶ See Peggy C. Davis, *Law as Micro-aggression*, 98 YALE L.J. 1559, 1576 (1989).

⁴⁷ See Robert Belton, *Mixed-Motive Cases in Employment Discrimination Law Revisited: A Brief Updated View of the Swamp*, 51 MERCER L. REV. 651, 662-63 (2000) (noting the inability of easily distinguishing direct and circumstantial evidence in the employment discrimination context); cf. Michael Selmi, *Subtle Discrimination: A Matter of Perspective Rather Than Intent*, 34 COLUM. HUM. RTS. L. REV. 657, 667 n.40 (2003) (“The distinction between direct and circumstantial evidence is often a difficult one to make, and in recent years courts have narrowed the range of behavior that is defined as ‘direct evidence’”).

⁴⁸ 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); see also Bowser, *Racial Profiling*, *supra* note 25 (discussing racial bias in medicine and reviewing medical literature demonstrating that African Americans receive lower quality health care than similarly situated white patients); Noah, *Racial Disparities in the Delivery of Health Care*, *supra* note 41 (discussing “racial bias in the delivery of [health] care”); Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 VILL. L. REV. 195 (2003).

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 procedure if they assume the patient does not live in an environment that is conducive to the aftercare needed for the best outcomes of the procedure

⁴⁹

....

While legal standards for discrimination have not always centered on intent, they do so now.⁵⁰ To prove a disparate treatment claim an individual must show that the defendant intentionally discriminated.⁵¹ Such a standard means that few of the discriminatory acts that occur in the health care system can be successfully litigated since most occur from “unthinking” or “unconscious” biases.

Psychiatric, psychological, and legal literature generally support the idea that, in our society, most contemporary discrimination is based more on unconscious bias and stereotyping rather than on conscious bigotry.⁵² As suggested by Professor Lawrence:

⁴⁹ See, e.g., MARIAN E. GORNICK, *VULNERABLE POPULATIONS AND MEDICARE SERVICES: WHY DO DISPARITIES EXIST?* 43 (Century Found. 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).

⁵⁰ See, e.g., Jessie Allen, *A Possible Remedy for Unthinking Discrimination*, 61 *BROOK. L. REV.* 1299 (1995) [hereinafter *Unthinking Discrimination*] (arguing that the failure to cover non-motivational forms of discrimination under Title VII “may actually discourage employers ... from acknowledging, let alone actively investigating, the risks of their own unconscious racism,” because “[t]hey receive no credit for doing so and may subject themselves to greater potential liability”).

⁵¹ *Id.*

⁵² Charles Lawrence, *The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism*, 39 *STAN. L. REV.* 317 (1987) [hereinafter *Unconscious Racism*]; see also IOM REPORT, *supra* note 2; David B. Oppenheimer, *Negligent Discrimination*, 141 *U. PA. L. REV.* 899, 967-72 (1993) (setting forth theory of negligent discrimination under Title VII); Sheri Lynn Johnson, *Unconscious Racism and the Criminal Law*, 73 *CORNELL L. REV.* 1016 (1988). See generally Ann C. McGinley, *Viva La Evolucion!: Recognizing Unconscious Motive in Title VII*, 9 *CORNELL J.L. & PUB. POL'Y* 415 (2000); Ann C. McGinley, *The Emerging Cronyism Defense and Affirmative Action: A Critical Perspective on the Distinction Between Colorblind and Race Conscious Decision Making Under Title VII*, 39 *ARIZ. L. REV.* 1003 (1997); *Unthinking Discrimination*, *supra* note 50, at 1299-1304 (asserting that the failure of civil rights laws is related to the reluctance to expand the definition of discrimination to include an objective standard that would address unconscious use of stereotypes); JODY DAVID ARMOUR, *NEGROPHOBIA AND REASONABLE RACISM: THE HIDDEN COSTS OF BEING BLACK IN AMERICA* 68-80 (New York Univ. Press 1997); Paul Brest, *The Supreme Court, 1975 Term-Forward: In Defense of the Antidiscrimination Principle*, 90 *HARV. L. REV.* 1, 6-7 (1976); Judith

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 decision-maker's beliefs, desires, and wishes.⁵³

The problem confronting the legal system is that an individual who holds a negative stereotype about a group is more likely to discriminate against an individual that fits the stereotype.⁵⁴ This stereotype-linked bias is both an automatic process and an unconscious one.⁵⁵ Furthermore, it occurs even among persons who are not prejudiced.⁵⁶ According to Professor David Williams, several factors contribute to the unbiased discrimination in health care:

First, healthcare providers are a part of the larger society that views racial and ethnic minorities negatively on multiple social dimensions . . . Second, research on

Olans Brown et al., *Some Thoughts About Social Perception and Employment Discrimination Law: A Modest Proposal for Reopening the Judicial Dialogue*, 46 EMORY L.J. 1487, 1493-97 (1997); Martha Chamallas, *The Architecture of Bias: Deep Structures in Tort Law*, 146 U. PA. L. REV. 463, 466-67 (1998); Peggy C. Davis, *Law as Microaggression*, 98 YALE L.J. 1559, 1560 (1989); Barbara J. Flagg, "Was Blind, But Now I See": *White Race Consciousness and the Requirement of Discriminatory Intent*, 91 MICH. L. REV. 953 passim (1993); Sheri Lynn Johnson, *Unconscious Racism and the Criminal Law*, 73 CORNELL L. REV. 1016 passim (1988); Linda Hamilton Krieger, *Civil Rights Perestroika: Intergroup Relations After Affirmative Action*, 86 CAL. L. REV. 1251, 1279, 1286-91 (1998) [hereinafter Krieger I]; Linda Hamilton Krieger, *The Content of Our Categories: A Cognitive Bias Approach to Discrimination and Equal Employment Opportunity*, 47 STAN. L. REV. 1161, 1164 (1995) [hereinafter Krieger II]; Anne C. McGinley, *Rethinking Civil Rights and Employment at Will: Toward a Coherent Discharge Policy*, 57 OHIO ST. L.J. 1443, 1463-73 (1996); David Benjamin Oppenheimer, *Negligent Discrimination*, 141 U. PA. L. REV. 899, 900-17 (1993); Michael Selmi, *Testing for Equality: Merit, Efficiency, and the Affirmative Action Debate*, 42 UCLA L. REV. 1251, 1283-89 (1995); David A. Strauss, *Discriminatory Intent and the Taming of Brown*, 56 U. CHI. L. REV. 935, 960-62 (1989); Pamela S. Karlan, *Discriminatory Purpose and Mens Rea: The Tortured Argument of Invidious Intent*, 93 YALE L.J. 111, 124-28 (1983).

⁵³ *Unconscious Racism*, *supra* note 52 (suggesting that racism is so ingrained that it can be classified neither as intentional nor as unintentional).

⁵⁴ David R. Williams, *Race, Health, And Health Care*, 48 ST. LOUIS U. L.J. 13 (Fall 2003); see IOM REPORT, *supra* note 2, at 171-173.

⁵⁵ *Id.*

⁵⁶ *Id.*

stereotypes indicates that encounters in the healthcare setting contain ingredients that enhance the likelihood of the use of stereotypes. Stereotypes are more likely to be activated under conditions of time pressure, the need to make quick judgments, cognitive overload, task complexity and when the emotions of anger or anxiety are present . . . Third, . . . [physicians view their Black patients] . . . more negatively than their white counterparts. . . . Physicians viewed Black patients (compared to their white counterparts) as less likely to adhere to medical advice, less likely to be kind, intelligent and educated, more likely to lack social support, and more likely to abuse alcohol and drugs.⁵⁷

However, notwithstanding that the discrimination is based on some unconscious or unthinking processes, an individual can change⁵⁸:

Social psychological research, reviewed here in four major sections, explains that stereotyping, prejudice, and discrimination have (1) some apparently automatic aspects and (2) some socially pragmatic aspects, both of which tend to sustain them. But, as research also indicates, change is possible, for (3) stereotyping, prejudice, and discrimination seem individually controllable, and consequently, (4) social

⁵⁷ Williams, *Race, Health, And Health Care*, *supra* note 54.

⁵⁸ See, e.g., Susan T. Fiske, *Controlling Other People: The Impact of Power on Stereotyping*, 48 AM. PSYCHOL. 621, 627 (1993) ("Our main program of research . . . has been showing that social structure affects attention, and if people pay more attention, at least some of them are less likely to stereotype"); Susan T. Fiske & Peter Glick, *Ambivalence and Stereotypes Cause Sexual Harassment: A Theory with Implications for Organizational Change*, J. SOC. ISSUES, 1995, at 97, 110-12 (discussing ways in which organizations can decrease the effect of stereotyping); Samuel L. Gaertner et al., *Reducing Intergroup Bias: Elements of Intergroup Cooperation*, 76 J. PERSONALITY & SOC. PSYCHOL. 388, 398 (1999) ("Any intergroup activity that induces the perception of common identity among the groups has the potential to reduce intergroup bias, with or without the components of intergroup cooperative interaction"); Steven L. Neuberg, *The Goal of Forming Accurate Impressions During Social Interactions: Attenuating the Impact of Negative Expectancies*, 56 J. PERSONALITY & SOC. PSYCHOL. 374, 374 (1989) (arguing that having a goal of forming accurate impressions reduces the detrimental impact of negative expectancies); Philip E. Tetlock, *Accountability: A Social Check on the Fundamental Attribution Error*, 48 SOC. PSYCHOL. Q. 227, 233 (1985) (discussing how accountability or requiring people to justify their decisions can result in "debiasing" under certain circumstances).

structure influences their occurrence. . . . The bad news is that people's habitual use of subjectively diagnostic information, certain information configurations, and perceived co-variation sustains stereotypes. . . . The good news is that people can sometimes control even apparently automatic biases, if appropriately motivated, given the right kind of information, and in the right mood. People therefore can make the hard choice.⁵⁹

Recognizing, the need to get at more than intentional discrimination the Office of Civil Rights (OCR) which was delegated the responsibility of enforcing Title VI and Department of Health and Human Services (DHHS) issued interpretive regulations which provided for disparate impact discrimination:⁶⁰

A recipient . . . may not . . . utilize criteria or methods of administration which have the *effect* of subjecting individuals to discrimination 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.⁶¹

The regulations defined a recipient as any public or private entity or individual that receives federal financial assistance.⁶² Federal financial assistance includes federal money awarded through grant, loan, or contract.⁶³ Because of these two definitions, Title VI, had the potential of having a broad range effect. Once a program or individual has been determined to violate Title VI, the program or individual "must take

⁵⁹ Susan T. Fiske, *Stereotyping, Prejudice and Discrimination*, in 2 HANDBOOK ON SOC. PSYCHOL. 357 (Daniel T. Gilbert et al. eds., 4th ed. 1998).

⁶⁰ See H.R. DOC. NO. 318 (1964). See generally Mitchell Rice & Woodrow Jones, Jr., *Public Policy Compliance/Enforcement and Black American Health: Title VI of the Civil Rights Act of 1964*, in HEALTH CARE ISSUES IN BLACK AMERICA: POLICIES, PROBLEMS AND PROSPECTS 100-17 (Woodrow Jones, Jr. & Mitchell F. Rice eds., 1987); Watson, *Reinvigorating Title VI: Defending Health Care Discrimination-it Shouldn't Be So Easy?*, *supra* note 31, at 943-48 (1990).

⁶¹ 45 C.F.R. § 80.3(b)(2) (1991) (emphasis added).

⁶² 45 C.F.R. § 80.3(i) (1991).

⁶³ 42 U.S.C.A. § 2000d-1 (1981); 42 U.S.C.A. § 2000d-4 (1981).

affirmative action to overcome the effects of prior discrimination."⁶⁴ Furthermore, the regulations went further and prohibited:

- Criteria or methods of administration which have the *effect* of subjecting individuals to discrimination;⁶⁵ criteria or methods of administration which have the *effect* of defeating or substantially impairing accomplishment of the objectives of the program;⁶⁶
- Difference in quality of services;⁶⁷
- Differences in quantity or the manner in which the benefit is provided;⁶⁸ and,
- Locating services with the purpose or effect of excluding individuals from the benefits of the program.⁶⁹

In theory then Title VI regulation should improve access to and quality of health care services. Title VI regulations clearly prohibit policies and practices that result in segregation within and between institutions. Title VI's regulations had the potential of forcing health care practitioners and institutions to evaluate their policies and practices that have a disparate impact on racial minorities.⁷⁰ Unfortunately, because of *Alexander v. Sandoval* and unique problems of health care discrimination, Title VI and its regulations are virtually useless.

In *Sandoval*, the court held in a five-to-four decision that despite a line of Title VI precedents, that disparate impact regulation issued under § 602 could only be enforced through a private right of action.⁷¹ Since the law requires a conscious discriminatory purpose or intent, individual discrimination claims cannot address the issue of unconscious discrimination and health care providers will not be "appropriately motivated" to make the hard choice.⁷²

⁶⁴ 45 C.F.R. § 80.3 (b)(6)(i) (1991).

⁶⁵ 45 C.F.R. § 80.3 (b)(1)(vii)(2) (1991).

⁶⁶ 45 C.F.R. § 80.3 (b)(1)(vii)(2) (1991).

⁶⁷ 45 C.F.R. § 80.3 (b)(1)(i) (1991).

⁶⁸ 45 C.F.R. § 80.3 (b)(1)-(3) (1991).

⁶⁹ *Id.*

⁷⁰ In *Alexander v. Choate*, 469 U.S. 287 (1985), the Supreme Court made it clear that a claim seeking a remedy for discrimination based on disparate impact under Title VI must involve a violation of agency regulations promulgated under § 602.

⁷¹ See *Alexander v. Sandoval*, 532 U.S. 275, 280 (2001).

⁷² See, e.g., *Unthinking Discrimination*, *supra* note 50; Interestingly, some members of Congress clearly understand the difference between conscious and unconscious bias. For instance, in its discussion of the American with Disabilities Act (ADA), several members

Even without the problem with Sandoval Title VI enforcement has been problematic.⁷³ First, although required by regulation to produce data,⁷⁴ the Office of Civil Right's ("OCR") Title VI enforcement effort has produced little consistent data for evaluating Title VI compliance.⁷⁵ Second, there has been "little uniformity in how different states handle Title VI requirements, little guidance, little analysis of the information collected by this process, no research and development."⁷⁶ Third, Title VI lacks specific definitions of prohibited discrimination and acceptable remedial action.⁷⁷ Fourth, OCR has relied on individual complaints to enforce Title VI.⁷⁸ Finally, Title VI would have limited application to health care treatment discrimination since HEW has interpreted Title VI to not apply to private physicians who received money for treating patients covered under Medicare Part B.⁷⁹ Thus, under Title VI physicians would not be recipients of federal financial assistance and consequently not covered by Title VI.⁸⁰

Taking the "even if" a step further, even if the problems with Title VI enforcement did not exist and Title VI functioned perfectly; the health care industry presents unique problems that would still make Title VI ineffective. Furthermore, the health care system presents several additional problems. First, as with the situation when racial minorities use housing

explained that the ADA was intended to address "institutional, structural, and psychological barriers." 136 CONG. REC. H2599, H2622 (daily ed. May 22, 1990) (statement of Rep. Hoyer); *see also* 135 CONG. REC. S10765, S10802 (daily ed. Sept. 7, 1989) (statement of Sen. Heinz).

⁷³ *See, e.g.,* Watson, *Reinvigorating Title VI: Defending Health Care Discrimination-It Shouldn't Be So Easy?*, *supra* note 31; Racist Health Care, *supra* note 25; Lado, *Breaking The Barriers Of Access To Health Care: A Discussion Of The Role Of Civil Rights Litigation And The Relationship Between Burdens Of Proof And The Experience Of Denial*, *supra* note 41; Hampton, *Title VI Challenges By Private Parties To The Location Of Health Care Facilities: Toward A Just And Effective Action*, *supra* note 41.

⁷⁴ 28 C.F.R. § 42.406(a) (1992); 45 C.F.R. § 80.6(b) (1991).

⁷⁵ *See, e.g.,* Sidney Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C. L. REV. 1647 (1993).

⁷⁶ *See, e.g.,* Smith, *HEALTH CARE DIVIDED*, *supra* note 40.

⁷⁷ *See, e.g.,* 45 C.F.R. § 80.3(b) (1991); Watson, *Health Care in the Inner City*, *supra* note 75.

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *But see* Lesley v. Chie, 250 F.3d 47, 53 (1st Cir. 2001) (discussing physicians' receipt of Medicaid funds in relationship to the Rehabilitation Act.); Howe v. Hull, 874 F. Supp. 779, 789 (N.D. Ohio 1994) (discussing physicians' receipt of Medicare and Medicaid funds in relationship to the Rehabilitation Act); However, it is open question whether physicians who receive payment through a managed care plan will be covered.

and lending institutions, individuals are, for the most part, totally unaware that the provider or institution has discriminated against them. Similarly, because of the very specialized knowledge required in medical care, individuals can be totally unaware that the provider has injured them. Finally, the health care system, through managed care, has actually built in incentives that encourage “unconscious” discrimination. Because of these issues, an appropriate legal structure is essential to eliminating discrimination in health care.

IV. STATE HEALTH CARE ANTI-DISCRIMINATION ACT

In an effective public health policy, appropriate state and federal laws must be available to eliminate discriminatory practices in health care. Thus, the crux of the problem, given managed care, the historical inequity in health care, and “unthinking discrimination,” the laws do not address the current barriers faced by minorities. The executive branch, the legislatures and the courts are singularly reluctant to hold health care institutions and providers responsible for institutional racism. As the United States Commission on Civil Rights found:

There is substantial evidence that discrimination in health care delivery, financing and research continues to exist. Such evidence suggests that Federal laws designed to address inequality in health care have not been adequately enforced by federal agencies . . . [Such failure has] . . . resulted in a failure to remove the historical barriers to access to quality health care for women and minorities, which, in turn has perpetuated these barriers.⁸¹

Health Care Anti-Discrimination Act should be enacted which would (1) recognize multiple forms of discrimination (2) authorize and fund testers, (3) assure fines & regulatory enforcement (4) require a health scorecard/report for health agency, provider or facility, and (5) require data collection and reporting.

⁸¹ See, e.g., U.S. COMMISSION ON CIVIL RIGHTS II, *supra* note 4, at 275-276.

A. Recognize Multiple Forms of Discrimination

Racial inequity in medical treatment rarely occurs because of overt, intentional discrimination behavior. Most race discrimination that occurs in health care is probably the result of subconscious bias, disproportionate impact of policies and practices, disparate impact. A state law on health care discrimination would at a minimum define discrimination in a way that included: intentional discrimination, subtle discrimination,⁸² unthinking discrimination⁸³ and disparate impact.⁸⁴ The law should define intentional discrimination to include knowledge of disparate impact and failure to take effective steps to reduce impact. Furthermore, any affirmative defenses, such as business necessity, should be limited and narrowly defined.

B. Authorize and Fund the Use of Medical Testers

To discourage health care discrimination, an 'aggrieved person' should include not only the individual who has been injured, but also one who believes that he or she will be injured, as well as individuals engaged as testers and organizations engaged in testing. In testing, the testing organization sends persons pretending to be patients who share common traits or symptoms except their race to health care facilities or providers to prove that patients of a particular race receive different treatment.⁸⁵ This is

⁸² Subtle discrimination is not necessarily the same as unconscious discrimination. Conscious discrimination can be directed in subtle ways. Michael Selmi, *Response to Professor Wax Discrimination as Accident: Old Whine, New Bottle*, 74 IND. L.J. 1233 (1999); see also ELIZABETH YOUNG-BRUEHL, *THE ANATOMY OF PREJUDICES* 73 (Harvard Univ. Press 1996); Selmi, *Subtle Discrimination: a Matter of Perspective Rather than Intent*, *supra* note 47.

⁸³ See, e.g., *Unthinking Discrimination*, *supra* note 50 (advocating strict liability for unconscious discrimination).

⁸⁴ Cf. Justin D. Cummins, *Refashioning the Disparate Treatment and Disparate Impact Doctrines in Theory and in Practice*, 41 HOW. L. J. 455, 468 (1998) (suggesting that problem is not the requirement of intent but how discriminatory intent is defined and proposing that a more comprehensive intent standard, which includes unconscious bias, be adopted); Amy Wax, *Discrimination as Accident*, 74 IND. L.J. 1129, 1206 (1999) (asserting that the costs of remedying unconscious discrimination are too high for employers to bear, and the victims of discrimination are the "cheapest cost avoiders").

⁸⁵ See, e.g., Stan Dorn et al., *Anti-Discrimination Provisions and Health Care Access*, 20 CLEARINGHOUSE REV. 439, 441, 441 n.27 (1986); *Desnick v. American Broadcasting*, 44 F.3d 1345, 1352 (7th Cir. 1995) (use of test patients with concealed cameras did not support claim for trespass under Illinois law, infringement of right of privacy, or illegal wiretapping).

important because much of health care discrimination goes unnoticed, unsuspected, undetected, or unreported.

Even in cases where discrimination is suspected, the victim will have an almost impossible time developing adequate proof because there will be almost no opportunity to witness better treatment to a similarly situated white patient. "Testing" could provide both evidence in the individual case and some accurate empirical data on the overall rate at which discrimination occurs in health care.⁸⁶ Testing has been widely used to enforce Title VIII,⁸⁷ which prohibits discrimination in the sale, advertising, and rental of housing.⁸⁸ However, while use of tests under Title VIII is well-settled, it is an issue of great debate in other areas, such as employment discrimination under Title VII⁸⁹ and section 1981 of the Civil Rights Act of 1866.⁹⁰ A statute that authorizes the use of testers will bypass that debate in the courts because the Supreme Court has already noted that "Congress may enact statutes creating legal rights, the invasion of which creates standing, although no injury would exist without the statute."⁹¹

⁸⁶ See, e.g., Ian Ayres, *Fair Driving: Gender and Race Discrimination in Retail Car Negotiations*, 104 HARV. L. REV. 817 (1991) (conducting rigorous testing for gender and race discrimination in new-car purchase negotiations and disclosing that women and minorities fare significantly worse in such negotiations than white males); Stephen E. Haydons, *A Measure of Our Progress: Testing for Race Discrimination in Public Accommodations*, 44 UCLA L. REV. 1207 (1997).

⁸⁷ 42 U.S.C. § 3604.

⁸⁸ See, e.g., Haydons, *A Measure of Our Progress: Testing for Race Discrimination in Public Accommodations*, *supra* note 86; *Havens Realty Corp. v. Coleman*, 455 U.S. 363 (1982) (unanimous Court endorsing the use of testers).

⁸⁹ See, e.g., Michael J. Yelnosky, *Filling an Enforcement Void: Using Testers to Uncover and Remedy Discrimination in Hiring for Lower-Skilled, Entry-Level Jobs*, 26 U. MICH. J.L. REFORM 403 (1993) (arguing that Congress should amend Title VII to give the EEOC the power to use testers to uncover discrimination in hiring for lower-skilled, entry-level jobs); Alex S. Navarro, Note, *Bona Fide Damages for Tester Plaintiffs: An Economic Approach to Private Enforcement of the Antidiscrimination Statutes*, 81 GEO. L.J. 2727 (1993) (arguing that testers should receive damage awards comparable to non-tester plaintiffs).

⁹⁰ See, e.g., Michelle Landever, Note, *Tester Standing in Employment Discrimination Cases Under 42 U.S.C. § 1981*, 41 CLEV. ST. L. REV. 381 (1993) (arguing that employment testers have standing to sue under § 1981).

⁹¹ *Linda R.S. v. Richard D.*, 410 U.S. 614, 617 n.3 (1973) (citing *Hardin v. Kentucky Utilities Co.*, 390 U.S. 1, 6, (1968)).

C. Provide a Private and Organizational Right of Action

An anti-discrimination health care statute would provide for a private right of action and organizational right of action. The private right of action would assure that individuals (including testers) would have standing to sue not only under the statute but also under any implementing regulations; thus, avoiding the problem that occurred in federal civil rights enforcement. Furthermore, there are many reasons why limiting enforcement to state agencies may be inadequate. For instance, the agency may not have sufficient staff to devote the resources necessary to enforce the civil rights violations.⁹² Administrative complaints with state agencies rather than going to court may limit some avenues of redress. State agencies may be limited in their capacity to mandate redress for aggrieved plaintiffs.⁹³ Without a private right of action, racial discrimination in health care will be impossible to eliminate.⁹⁴

In addition to the private right of action, an organizational right of action is essential to allowing testing to be carried out more broadly by civil rights organizations. These organizations and testers would have standing to sue and could recoup the costs of testing programs. This would provide the necessary incentive for civil rights organizations to create testing programs and make their existence known to potential victims of discrimination.

D. Establish Equality Health Care Council

The act should establish "Health Care Council," patterned after Fair housing councils. This council could serve several distinct functions, including educating the public, training health care providers and institutions, providing counseling and health care-finding services to individuals, investigating discrimination complaints—mostly through testing—and pursuing legal remedies.⁹⁵ Such council would provide a focal point, anti-discrimination work in health care.⁹⁶ It could easily be an extension of existing state minority health efforts. Thus, when someone

⁹² See, e.g., Derek Black, *Picking up the Pieces after Alexander V. Sandoval: Resurrecting a Private Cause of Action for Disparate Impact*, 81 N.C. L. REV. 356 (2002).

⁹³ *Id.*

⁹⁴ See *id.*

⁹⁵ See, e.g., Haydons, *A Measure of Our Progress: Testing for Race Discrimination in Public Accommodations*, *supra* note 86.

⁹⁶ See, e.g., *Fair Housing Council Finds Discrimination Against Hispanics in DC*, 66 Number 40 Interpreter Releases 1154 (Oct. 16, 1989).

believes she has been discriminated against in a health care, she would have somewhere to turn for help.

E. Prevailing Party Attorney Fees

The health care anti-discrimination statute would provide for attorneys' fees for a prevailing party.⁹⁷ Many federal statutes authorize attorneys' fees for a prevailing party.⁹⁸ The statute should grant prevailing party status when, because of the law suit, a party's ends are accomplished. Under the catalyst theory, the focus is on whether the party obtained its desired result, despite whether the party obtained a favorable ruling. Prevailing Party Attorney Fees would help to provide the financial incentives needed to pursue.⁹⁹

F. Punitive Damage, in Part or in Whole, to Fund Monitoring and Assessment Programs

Compensatory damages make discrimination victims whole for injuries to their injuries.¹⁰⁰ Punitive damages, on the other hand, punish past conduct, teach defendants not to commit these acts again and deter others from similar behavior.¹⁰¹ Similar to split-recovery statutes,¹⁰² all or

⁹⁷ See, e.g., Macon Dandridge Miller, *Catalysts as Prevailing Parties under the Equal Access to Justice Act*, 69 U. CHI. L. REV. 1347 (2002).

⁹⁸ See, e.g., Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 259 (codified at 42 U.S.C. § 2000e-5(k) (1994)); Civil Rights Attorney's Fees Awards Act of 1976, Pub. L. No. 94-559, 90 Stat. 2641 (codified at 42 U.S.C. § 1988(b) (1994 & Supp. 2000)); Equal Access to Justice Act, Pub. L. No. 96- 481, 94 Stat. 2325 (1980) (codified at 5 U.S.C. § 504, 28 U.S.C. § 2412 (1994 & 1998 Supp.)); 66 Stat. 813 (1952) (codified at 35 U.S.C. § 285 (1994)).

⁹⁹ See, e.g., *Stanton v. Southern Berkshire Regional School District*, 197 F.3d 574, 577 (1st Cir. 1999) (interpreting prevailing party to include catalysts); *Marbley v. Bane*, 57 F.3d 224, 234 (2d Cir. 1995) (recognizing the catalyst theory as a viable form of recovery as a prevailing party); *Baumgartner v. Harrisburg Housing Authority*, 21 F.3d 541, 551 (3d Cir. 1994) (holding that "there is no legal impediment to application of the 'catalyst theory' to show that plaintiffs were 'prevailing parties' notwithstanding the absence of a judgment or consent decree"); *Environmental Defense Fund, Inc. v. EPA*, 716 F.2d 915, 919 (D.C. Cir. 1983) (holding that a party can achieve prevailing party status without having received a final judgment in its favor).

¹⁰⁰ Jason P. Pogorelec, *Under What Circumstances Did Congress Intend to Award Punitive Damages for Victims of Unlawful Intentional Discrimination Under Title VII?*, 40 B.C. L. REV. 1269 (1999).

¹⁰¹ See e.g. *id.*; H.R. REP. NO. 102-40(I) at 64-65 (1991), reprinted in 1991 U.S.S.C.A.N. 549, 602-03.

¹⁰² As of 2003, 12 states had split-recovery statutes. The twelve states are: Alaska,

part of the punitive damages should be placed into a fund that would ultimately be used to promote equality health care including discrimination testing.¹⁰³

G. Require Data Collection and Reporting

Current data collection efforts fail to capture the diversity of racial and ethnic communities in the United States.¹⁰⁴ Data are aggregated information on subgroups within the five racial and ethnic categories that are not collected systematically.¹⁰⁵ Further, racial and ethnic classifications are often limited on surveys and other data collection instruments, and minorities are often misclassified on vital statistics records and other surveys and censuses.¹⁰⁶ To fully understand the health status, of all individuals, as well as to recognize the barriers they face in obtaining quality health care it is important to collect the most complete data on underrepresented groups, and sub-populations.¹⁰⁷ The lack of data on these groups makes it difficult to conduct research studies and comparative analyses.¹⁰⁸ Furthermore, the lack of a uniform data collection method makes obtaining an accurate and specific description of race discrimination in health care difficult. The existing data collection does not allow for regularly collecting race data on provider and institutional behavior.¹⁰⁹

Colorado, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Missouri, New York, Oregon, and Utah.

¹⁰³ See, e.g., Mathew J. Klaben, *Split-Recovery Statutes: The Interplay of the Takings and Excessive Fines Clauses*, 80 CORNELL L. REV. 104, 105 (1994); Leo M. Stepanian II, Comment, *The Feasibility of Full State Extraction of Punitive Damages Awards*, 32 DUQ. L. REV. 301, 317 (1994).

¹⁰⁴ See, e.g., David R. Williams, *Race/Ethnicity and Socioeconomic Status: Measurement and Methodological Issues*, 26 INT'L J. HEALTH SERVICES 483, 483-505 (1996); Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 AM. J.L. & MED. 203 (2001).

¹⁰⁵ See, e.g., U.S. COMMISSION ON CIVIL RIGHTS I, *supra* note 2, at 50-52.

¹⁰⁶ See, e.g., Williams, *Race/Ethnicity and Socioeconomic Status: Measurement and Methodological Issues*, *supra* note 104.

¹⁰⁷ See, e.g., U.S. COMMISSION ON CIVIL RIGHTS I, *supra* note 2, at 50-52.

¹⁰⁸ Williams, *Race/Ethnicity and Socioeconomic Status: Measurement and Methodological Issues*, *supra* note 104.

¹⁰⁹ See *Madison-Hughes v. Shalala*, 80 F.3d 1121, 1123 (6th Cir. 1996) (dismissing for lack of subject matter jurisdiction); U.S. COMMISSION ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT TO ENSURE NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS 246 (1996); Lado, *Unfinished Agenda: the Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery*, *supra* note 25.

Given the array of potential issues, some researchers have argued that health data should not be disaggregated by race.¹¹⁰ It could be argued that the use of race in health data promotes and maintains the view that race is a biological concept or that racial categorizations perpetuate and encourage racial fragmentation. Such views see potential for harm from the use of race.

However, there are a number of important and compelling reasons for disaggregating health status and health care data by race. First, the use of race is not the cause of racism but the result of racism. That is, individuals have been discriminated against based on color; established hierarchy and superiority are based on color. Consequently, racism and racial discrimination will continue to exist (that is, discrimination based on color) even if terminology change or cease to exist. For instance, even though race data are not collected in the European Union in the same way as they are in the United States, racism and racial discrimination continues to exist as a worldwide problem. Here in the United States, even when one controls for socioeconomic status, health status and health care differentials continue to exist.

Second, racism and racial discrimination have implications for every institution and social practice. Health status is impacted by racial discrimination in housing, employment, environment, education, and other institutions. Third, calls to not disaggregate data ignore the power and status differentials that exist among all racial groups.¹¹¹ This point is illustrated when one considers the disproportionate percentage of racially disadvantaged individuals who are poor. Fourth, as long as some groups continue to experience discrimination, it is important to monitor their well being.¹¹² Fifth, to fully understand the health status of all individuals as well as to recognize the barriers they face in obtaining quality health care, it is important to collect the most complete data on "racially disadvantaged" groups and "sub-groups".¹¹³ The lack of a uniform data collection method makes obtaining an accurate and specific description of racial discrimination in health care difficult, if not impossible. Such data collection has to include collecting data on provider and institutional behavior.

¹¹⁰ C. Bagley, *A Plea for Ignoring Race and Including Insured Status in American Research Reports on Social Science and Medicine*, 40 SOC. SCI. MED. 1017, 1017-19 (1995).

¹¹¹ Williams, *Race, Health and Health Care*, *supra* note 54, at 322-333.

¹¹² *Id.*

¹¹³ Randall, *Racist Health Care*, *supra* note 25, at 127-194.

“Although not useful as a biological category, race has been and is likely to continue to be an important social category. It is what sociologists call a master status—a central determinant of social identity and obligations, as well as of access to societal rewards and resources. From our earliest health records, race has been an empirically robust predictor of variations in morbidity and mortality. Collecting the appropriate data on race can facilitate ongoing monitoring of the magnitude of differentials, enhanced understanding of their causes and the development of effective interventions to address them.”¹¹⁴

Race matters because racism and racial discrimination matter.¹¹⁵ Disaggregating data based on race is important because it helps to make the impact of racism and racial discrimination visible and thus allows us to address the root problem.

H. Require a Health Report Card for Health Agency, Provider or Facility¹¹⁶

If we are serious about eliminating racial discrimination, the systematic collection and reporting of data from each health care provider on racial inequities in the use of services and the choices of diagnostic and therapeutic alternatives would provide an additional tool in civil rights monitoring.¹¹⁷ The “report card” approach is not new and is being done to “assure accountability, consumer choice, and goal-directed action.”¹¹⁸ Existing and proposed health care “report cards” could be used and only need to be stratified by race.¹¹⁹ As Sidney Watson discussed:

¹¹⁴ Williams, *Race, Health and Health Care*, *supra* note 54, at 322-333.

¹¹⁵ JAMES M. JONES, *PREJUDICE AND RACISM* 352-356 (McGraw-Hill 1997).

¹¹⁶ See, e.g., Smith, *Addressing Racial Inequities in Health Care: Civil Rights Monitoring and Report Cards*, *supra* note 40.

¹¹⁷ Smith, *HEALTH CARE DIVIDED*, *supra* note 40, at 325; H. Jack Geiger, *Race and Health Care—An American Dilemma*, 335 *NEW ENG. J. MED.* 815, 816 (1996); Bowser, *Racial Profiling*, *supra* note 25.

¹¹⁸ See Smith, *Addressing Racial Inequities in Health Care: Civil Rights Monitoring and Report Cards*, *supra* note 40.

¹¹⁹ See, e.g., Smith, *HEALTH CARE DIVIDED*, *supra* note 40, at 326; NAT'L COMM. QUALITY ASSURANCE, *HEALTH PLAN AND EMPLOYER DATA INFORMATION SET* (version 3.0 1998); Alain C. Enthoven & Carol B. Vorhaus, *A Vision of Quality In Health Care Delivery*, *HEALTH AFFAIRS* (May/June 1997); Bowser, *Racial Profiling*, *supra* note 25.

Reporting race-based data on health care is relatively easy once we get over our squeamishness about talking about race and recognize the need for this information. Physicians already gather information on patient race as part of a standard medical history. All this is needed is to compile and report racial and ethnic information in a format that protects patient confidentiality and privacy. . .¹²⁰

Report cards that reflect racial disparities will provide a strong evidence that racism, “intentional or unintentional, institutional or individual—is affecting patient care.”¹²¹

I. Assure Adequate Fines and Regulatory Enforcement

The importance of rigorous enforcement of regulation as a primary vehicle for policing health services cannot be overemphasized. The collection of data and the development of a report card need the teeth of regulatory enforcement. Thus, a statute which allows significant civil penalty to be assessed for violation of regulations designed to eliminate racial inequities is important to compliance. Current administrative penalty involves termination of funds. Such a step is highly unlikely; consequently, it is the effective equivalent of having no penalty at all. If substantial fines were mandated and collected for violating anti-discrimination law, then such fines could be collected and deposited directly into a restricted account that could be used only to enhance and improve racial inequities.

V. Conclusion

The questions raised are: why modifying existing federal law (i.e., Title VI) is insufficient or why not adopt a Health Care Anti-Discrimination Law on the federal level? My discussion above should answer the first question. Title VI is hopelessly flawed and minor tinkering will not be sufficient to make it an effective tool. As to the question of why not a new federal law, frankly the answer is political feasibility. From a political perspective, the antagonism to civil rights makes it highly unlikely such an approach will work. Furthermore, the

¹²⁰ See, e.g., Sidney D. Watson, *David Barton Smith's Health Care Divided: Race and Healing a Nation*, 21 J. LEGAL MED. 601 (2000) (book review).

¹²¹ *Id.*

states are major players in the civil rights arena and have an infrastructure on which a new civil rights law could be based.

The discussion of discrimination in health care has been limited. That discussion has centered almost entirely around Title VI of the Civil Rights Act¹²² and on assuring access to facilities and providers.¹²³ In an effective public health policy, appropriate state and federal laws must be available to eliminate discriminatory practices in health care. Thus, the crux of the problem for the legal system: given managed care, the historical inequity in health care, and unthinking discrimination, what is the best way for the legal system to remedy racial discrimination in the health care system?

¹²² See, e.g., Watson, *Reinvigorating Title VI: Defending Health Care Discrimination--it Shouldn't Be So Easy?*, *supra* note 31; Smith, *HEALTH CARE DIVIDED*, *supra* note 40; Smith, *ADDRESSING RACIAL INEQUITIES IN HEALTH CARE: CIVIL RIGHTS MONITORING AND REPORT CARDS*, *supra* note 40; Randall, *Racist Health Care*, *supra* note 25.

¹²³ See, e.g., Noah, *Racial Disparities*, *supra* note 41; Hampton, *Title VI Challenges By Private Parties To The Location Of Health Care Facilities: Toward A Just And Effective Action*, *supra* note 41; Barbara A. Noah, *Racist Health Care?*, 35 *SAN DIEGO L. REV.* 135 (1998); Lado, *Breaking The Barriers Of Access To Health Care: A Discussion Of The Role Of Civil Rights Litigation And The Relationship Between Burdens Of Proof And The Experience Of Denial*, *supra* note 41.

