

Racial Disparities in the Delivery of Health Care

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I. INTRODUCTION

During the past few years, rationing has become an explicit feature in decisions concerning optimal delivery of health care services, and it poses difficult choices for health care providers and policymakers. Insurers and patients increasingly must balance the desire for access to every possible treatment against concerns about affordability. Cost-driven treatment decisions are an unavoidable reality for most patients.¹ Apparently, however, another more pernicious type of rationing occurs in this country, and it does not depend on factors such as the likelihood of an optimal outcome, the comparative efficacy of different available treatment modalities, or even the ability to pay for care. Instead, a growing body of evidence suggests that race adversely affects the quantity and quality of health care provided to minority patients. Although no one has found widespread overt racism by providers, such inequities in the delivery of health care services pose serious problems.² Ultimately, the medical establishment must face up to the reality that African American patients do not always receive equal treatment in the health care system.

President Clinton's recent initiative to create an advisory panel to promote a dialogue about racial problems has generated mixed reactions from the public; some applauded the move, but others expressed skepticism that government could improve race relations.³ Much of the public debate about race relations has focused on employment and

1. See generally David Orentlicher, *Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick*, 31 HARV. C.R.-C.L. L. REV. 49 (1996). Some patients are confronted with cost-driven treatment decisions directly via high premiums, deductibles, and co-payments paid out-of-pocket. Others, whose employers provide health coverage, experience cost constraints indirectly when managed care organizations restrict treatment access or options.

2. See Louis W. Sullivan, *From the Secretary of Health and Human Services*, 266 JAMA 2674, 2674 (1991) ("I contend that there is clear, demonstrable, undeniable evidence of discrimination and racism in our health care system. For example, each year since 1984, while the health status of the general population has increased, black health status has actually declined."); see also David R. Williams et al., *The Concept of Race and Health Status in America*, 109 PUB. HEALTH REP. 26, 26 (1994) (noting that, despite significant medical progress over the course of the twentieth century, African Americans "continue to bear a higher burden of death, disease, and disability.").

3. See Steven A. Holmes, *Many Uncertain About President's Racial Effort*, N.Y. TIMES, June 16, 1997, at B1. At a meeting of the race advisory panel, President Clinton urged the panel to develop a "compendium" of successful approaches to fostering racial harmony that have been used in different locations, and the President suggested that the panel publish these successful efforts so that they can be utilized elsewhere. See Steven A. Holmes, *President Nudges His Race Panel to Take Action*, N.Y. TIMES, Oct. 1, 1997, at A3.

university admissions. The role that conscious or unconscious racial bias may play in the health care context has, by comparison, attracted comparatively little public attention, though a growing number of studies appearing in the medical literature explicitly consider the race of patients as one potentially relevant variable. This Article attempts to frame the debate about racial justice in the delivery of health care services, first by surveying several examples of such disparities, and then by connecting these examples with the existing legal literature concerning the range of possible remedies for discrimination. In a society that remains pessimistic about race relations,⁴ the equitable provision of medical services represents one area that demands prompt and serious attention.

In general, the problem of inadequate access to health care for uninsured Americans contributes significantly to the problem of disparate health status among the races. This Article focuses only on the role of conscious and unconscious racial bias in the delivery of care and does not begin to address the larger issue of inadequate access to care at the outset. Improving access to health care for minorities will undoubtedly have a positive effect on these groups' overall health status; however, to the extent that racial bias in the delivery of care exists apart from problems of inadequate access, the disparity in health status between whites and African Americans will no doubt continue.⁵

Part II of this Article describes racial disparities in a variety of health care contexts including the utilization of Medicare services, the selection of recipients for cadaveric organ transplantation, access to drug therapy, institutionalization for mental illness, and the representation of racial and ethnic minority groups in clinical research. Part II closes with a

4. A recent Gallup poll revealed that 55% of Americans believe that race relations will "always be a problem" in the United States, while only 42% believe that a solution will eventually be reached. College-educated African Americans demonstrated the greatest level of pessimism about race relations; 65% of this group said that problems between the races would always exist. See Steven A. Holmes, *New Survey Shows Americans Pessimistic on Race Relations*, N.Y. TIMES, June 11, 1997, at A4.

5. Much of the discussion in this Article focuses on health disputes between whites and African-Americans, and only to a lesser extent on disparities between whites and other races. Some critical race theorists have criticized the application of conclusions about relations between whites and African-Americans to white relations with other racial minority groups. See, e.g., Juan F. Perea, *The Black/White Binary Paradigm of Race: The "Normal Science" of American Racial Thought*, 85 CAL. L. REV. 1213 (1997). Many of the proposed approaches to the problem of racial bias in health care discussed within this Article implicitly or explicitly reject a "one size fits all" approach to treatment decisions and communication issues in health care.

discussion of some of the problems inherent in measuring the degree of the disparate care problem and in isolating and evaluating the role that race plays in health care decisionmaking. Part III suggests potential solutions to the problem of disparate medical care for racial minorities, including possible constitutional and statutory remedies for past victims of disparate treatment, avenues for governmental enforcement of policies prohibiting discrimination, and other approaches for avoiding future inequalities in the delivery of medical services. This Article concludes that prospective approaches, such as education and regulatory responses to patterns of disparate care, provide the most promising avenues for addressing this troubling problem.

II. EXAMPLES OF RACIAL DISPARITIES IN HEALTH CARE DELIVERY

Examples of racial disparities in health care delivery abound. Differences in the care delivered to patients span a wide range of health services, from organ transplantation to sophisticated coronary care to basic preventive care. Overall, the gap in health status between the African American population and the white population continues to widen.⁶ The following examples illustrate the magnitude of the problem, as well as the complexities inherent in evaluating the role that race plays in decisions to provide medical treatment.

A. Provision of Medicare Services

A study recently published by a team of investigators affiliated with the Health Care Financing Administration (HCFA) presents startling evidence of racial inequities in the delivery of health services.⁷ Although previous studies have examined the utilization of health

6. Former Secretary of Health and Human Services Louis W. Sullivan has observed:

[E]ach year since 1984, while the health status of the general population has increased, black health status has actually declined. This decline is not in one or two health categories; it is across the board, from an infant mortality rate for blacks that is double that for whites to a life expectancy for black Americans that is 6 years less than that for white Americans.

Sullivan, *supra* note 2, at 2674; see also Durado D. Brooks et al., *Medical Apartheid*, 266 JAMA 2746, 2746-48 (1991) (describing the "wide disparity in . . . preventable disease incidence, and life expectancy between white citizens and people of color" in the United States and South Africa, and discussing several models of health care delivery designed to improve equality of access to care).

7. See Marian E. Gornick et al., *Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries*, 335 NEW ENG. J. MED. 791 (1996). The authors note, however, that the opinions expressed in their article do not necessarily reflect those of HCFA. See *id.* at 798.

services among different racial groups, they often used race as a surrogate for socioeconomic status; thus, these studies frequently attributed differences in the quality and quantity of care afforded to minority patients to disparities in income.⁸ The HCFA study represents one of the first attempts to control for income among different populations, allowing the investigators to identify variations in the utilization of health care services based on race alone.⁹

The HCFA investigators used Medicare administrative data from 1993 covering more than twenty-six million beneficiaries, combined with Census data on estimated household income, to determine whether and to what extent race and income affect the utilization of health care services and mortality.¹⁰ In addition to overall mortality rates, the investigators focused on four categories of health services: first, visits to physicians for ambulatory care and hospital discharges; second, hospitalizations for ischemic heart disease, coronary-artery bypass surgery, and a type of coronary angioplasty; third, mammography (an elective Medicare service) and hip-fracture repair (a non-elective Medicare service); and, fourth, the amputation of a lower limb and bilateral orchiectomy.¹¹

The data identified significant differences in mortality rates and in rates of utilization of health care services between white and African American patients. Among the HCFA study's findings, African American men were 19% more likely to die than white men (after adjusting for age and gender only). After adjusting for income, the ratio did not change dramatically; African American men were still 16% more likely to die than white men; African American women were 16% more

8. See, e.g., Robert A. Hahn & Donna F. Stroup, *Race and Ethnicity in Public Health Surveillance*, 109 PUB. HEALTH REP. 7 (1994); Kenneth C. Goldberg et al., *Racial and Community Factors Influencing Coronary Artery Bypass Graft Surgery for All 1986 Medicare Patients*, 267 JAMA 1473 (1992) (finding disparities in income to be an important factor in the differences in the rates of coronary artery bypass grafting between African American and white Medicare patients).

9. See Gornick et al., *supra* note 7, at 792.

10. An editorial accompanying the study suggests a pair of methodological weaknesses: the investigators relied solely on Medicare administrative data because they lacked access to medical records, and they used aggregated rather than individual income data. See H. Jack Geiger, Editorial, *Race and Health Care—An American Dilemma?*, 335 NEW ENG. J. MED. 815, 815-16 (1996).

11. See Gornick et al., *supra* note 7, at 792. Such amputations are frequently associated with complications of diabetes. Bilateral orchiectomy involves the surgical removal of the testicles to treat metastatic prostate cancer.

likely to die than white women (adjusting for income made no difference in this category). African American women were 25% less likely to have mammograms than white women, and African American patients of both sexes were 7% less likely to visit physicians for ambulatory care.¹²

The data also suggested a tendency on the part of health care providers to pursue less aggressive therapies for African American patients who did seek medical care. Certain types of procedures were performed less frequently on African American patients than on white patients, even after income adjustment. For example, white patients were at least twice as likely to undergo a type of coronary angioplasty, coronary-artery bypass surgery,¹³ and hip repair surgery.¹⁴ In contrast, other procedures were performed more frequently among African American patients. After adjusting for income, African American patients were over three times more likely than white patients to have a partial or total amputa-

12. *See id.* at 797 (tbl.2).

13. Other studies also have examined racial variations in the use of sophisticated coronary procedures. In one recent study, researchers at Duke University compared a population of over 12,000 patients with coronary disease, 10.3% of whom were African Americans. The study calculated rates of angioplasty and bypass surgery, with and without adjusting for severity of the disease and related factors. Taking these factors into account, African Americans were 13% less likely than white patients to undergo angioplasty and 32% less likely to have bypass surgery. *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 (1997). The significant variation in rates of angioplasty is particularly disturbing because, as the study authors point out, the differences did not result from variables such as disease severity, co-existing illnesses, or even varying rates of access to subspecialty care. *See id.* at 484. The study authors also noted that “the patient’s (or the physician’s) preferences for particular cardiac interventions may differ according to race. The decision to undergo cardiac intervention is a complex one and can be influenced by the patient’s symptoms, the perceived risks and benefits of the procedure, and other factors, such as one’s trust in medical approaches involving advanced forms of technology. Because these preferences can alter the final therapeutic decision in many instances, physician-patient interactions become key to understanding practice patterns.” *See id.*; *see also* Earl Ford et al., *Coronary Arteriography and Coronary Bypass Survey among Whites and Other Racial Groups Relative to Hospital-based Incidence Rates for Coronary Artery Disease*, 79 *AM. J. PUB. HEALTH* 437, 437-39 (1989) (noting that, among patients discharged from hospitals with a diagnosis of anterior myocardial infarction, African American men had a rate of this condition that was three-fourths the rate for white men, but that African American men were only half as likely to undergo angiography and one-third as likely to have bypass surgery as white male patients, even where other factors indicated that the severity of the illness between the groups of patients was similar at the time of admission).

14. *See* Gornick et al., *supra* note 7, at 797. The authors concluded, however, that, with regard to hip fracture repair and other non-elective procedures, the rates did not suggest any racial inconsistencies. Because osteoporosis in the femur is 2.4 times more prevalent among white women than African American women over the age of 50, no real disparity exists. *See id.* at 798.

tion of the leg, and they were more than twice as likely to undergo bilateral orchiectomy as a treatment for prostate cancer.¹⁵ Significantly, in most of these comparisons, adjustments for income differentials did little to diminish the racial disparities.¹⁶ The greatest effects of the adjustment for income occurred in the figures for mammography and visits to physicians for ambulatory care. For example, among the least affluent African American women, the mammography rate was 39% lower than among the most affluent African American women.¹⁷

Of course, differences in access to, or the utilization of, preventive care over a patient's lifetime may account for some of the observed disparities in mortality rates and choice of treatment; once patients become eligible for Medicare at age 65, these long-developing differences in health status may be irreversible. The data also may simply reflect differences in the relative health status of the patients in the two groups arising from factors unrelated to differences in access to care.¹⁸ The

15. *See id.* at 797 tbl.2. Diabetes is only 1.7 times as prevalent in elderly African American patients as in white patients, which suggests that the difference in rates of amputation of a lower limb is not completely explained by differences in the prevalence of diabetes. *See id.* at 791. As with the data on hip fracture repair, the data on bilateral orchiectomy may suggest a disparity that does not really exist, because African American men have 2.2 times the rate of metastatic prostate cancer as white men. *See id.* at 792. However, other troubling disparities, such as lower rates of access to primary and preventive care among African Americans, may contribute to the differing rates of this advanced form of prostate cancer. *See* Scott A. Optenberg et al., *Race, Treatment, and Long-Term Survival From Prostate Cancer in an Equal-Access Medical Care Delivery System*, 274 JAMA 1599, 1604-05 (1995) (concluding that, after adjusting for stage of disease, African American and white patients receiving equal medical treatment and exhibited similar survival rates for prostate cancer).

16. *See* Gornick et al., *supra* note 7, at 791, 797 tbl.2. After adjusting the mortality and health services utilization rates for income-related differences, the investigators found that racial differences diminished somewhat, but that the overall effect of the income adjustment was relatively insignificant.

17. *See id.* at 794-95.

18. The authors of the HCFA study suggested that a variety of factors, such as educational, cultural, and behavioral variables, differences in supplementary insurance, and the availability of services, may contribute to racial disparities in health care. *See id.* at 798; *see also* AMA Council on Ethical and Judicial Affairs, *Black-White Disparities in Health Care*, 263 JAMA 2344, 2344 (1990) (noting that African Americans are more likely to require health care but less likely to receive it); Jan Blustein & Beth C. Weitzman, *Access to Hospitals with High-Technology Cardiac Services*, 85 AM. J. PUB. HEALTH 345, 346-50 (1995) (discussing the relative scarcity of high-technology health care facilities in predominantly African American neighborhoods, and noting that African American patients may be less likely to travel to such facilities to receive high-quality care).

data do not by themselves indicate that physicians or insurers provide suboptimal medical care to minority patients.¹⁹

Even so, because the studied population shares a common insurer (Medicare), and thus enjoys uniformity of coverage for the services analyzed, the conclusions of the HCFA study deserve serious consideration. This lack of an "insurance discrimination" factor (whereby under-insurance may account for observed treatment differences), together with the adjustment for income among the white and African American patients studied, strongly underscores the significance of the findings. The HCFA study clearly demonstrates that equal health insurance by itself does not ensure equal care.

B. Allocation of Organs for Transplantation

Racial inequities appear in a variety of other health care contexts. Recent statistics suggest some disparities in the rationing of expensive, lifesaving procedures and technology. In the area of organ transplantation, for example, demand far exceeds supply,²⁰ and the debate continues about how best to distribute organs available for transplant.²¹ In 1987, Congress created the Organ Procurement and Transplantation Network (OPTN).²² The United Network for Organ Sharing (UNOS), a private non-profit organization, operates OPTN under contract with the federal government, coordinating procurement and allocation functions,

19. The study reported only aggregated data. Disaggregating the data may reveal additional useful information. For example, if the rates of usage remain consistent across doctors and institutions, this would suggest a systemic problem. However, if more pronounced treatment disparities appear at certain institutions or in certain regions of the country, the possibility of conscious discrimination at some facilities becomes more compelling.

20. See Phyllis Coleman, "Brother Can You Spare a Liver?" *Five Ways to Increase Organ Donation*, 31 VAL. U. L. REV. 1, 14-25 (1996) (discussing various proposals to increase rates of organ donation).

21. In 1996, over 34,000 patients in the United States were waiting for a kidney. See *Testimony of Cass Franklin, M.D., DHHS Liver Allocation Hearings, Dec. 10, 1996*, (visited April 16, 1998) <www.unos.org> [hereinafter *Franklin Testimony*]. Approximately one-third of patients waiting for a heart or liver transplant die before an organ becomes available, and the number of actual donors is significantly lower than the source potential. See Raja B. Khauli, *Issues and Controversies Surrounding Organ Donation and Transplantation: The Need for Laws That Ensure Equity and Optimal Utility of a Scarce Resource*, 27 SUFFOLK U. L. REV. 1225, 1225-26 (1993). Federal law prohibits the selling of organs or tissue. See 42 U.S.C. § 274(e) (1994).

22. See National Organ Transplant Act, Pub. L. No. 98-507, 98 Stat. 2339 (1987) (codified at 42 U.S.C. §§ 273-74 (1994)).

and UNOS also works to develop equitable policies for organ distribution.²³

For a variety of reasons, African American patients wait longer to obtain kidney and other organ transplants than white patients.²⁴ In part, organ donation rates by African Americans have lagged, though donations among minority groups recently have increased.²⁵ Whites continue to account for most organ donations, and this limits the number of organs available for minorities where immunologic matching is deemed essential.²⁶ In addition, demand for transplants may be higher for racial minorities. For instance, African Americans constitute 12% of the population in the United States but account for 34% of persons suffering from end stage renal disease (ESRD).²⁷ The confluence of these supply and demand factors results in longer waiting times for racial minorities; African Americans recently accounted for more than one-third of patients on the waiting list to receive kidneys.²⁸

Before the allocation process begins, physicians must first evaluate potential transplant candidates to determine whether they meet medical

23. See Organ Procurement and Transplantation Network, 42 C.F.R. pt. 121 (1998). In order to guarantee that transplant centers comply with UNOS policies, Congress made Medicare and Medicaid reimbursement dependent upon membership in the OPTN and adherence to UNOS rules. See 42 U.S.C. § 1320b-8(a)(1)(B) (1994).

24. See Khauli, *supra* note 21, at 1231 & n.30; see also Ian Ayres et al., *Unequal Racial Access to Kidney Transplantation*, 46 VAND. L. REV. 805 (1993) (discussing reasons for disparate access to kidney transplantation among different racial groups).

25. See Stuart Auerbach, *Organ Donations by Minorities Rise*, WASH. POST, Feb. 27, 1996, Health News, at 7 (noting that African Americans accounted for 11.5% of the 5100 organs that were donated in 1994, which represented only slightly less than this group's 12.1% share of the population).

26. See Khauli, *supra* note 21, at 1231-32; see also Fred P. Sanfilippo et al., *Factors Affecting the Waiting Time of Cadaveric Kidney Transplant Candidates in the United States*, 267 JAMA 247, 251 (1992) (noting that differences in antigen distribution between white and African American patients "result in a biologic disadvantage to" the latter).

27. See Robert S. Gaston et al., *Racial Equity in Renal Transplantation*, 270 JAMA 1352, 1354 (1993). See also *Franklin Testimony*, *supra* note 21. Dr. Franklin noted that, of the 34,000 patients waiting for a kidney, 34% are African Americans, 9% are Hispanic, and 5% are Asian, and explained that, with regard to transplantation of organs other than kidneys, allocation inequities do not appear to pose a problem, but race-related concerns exist nonetheless. For example, because minorities historically tend to rely disproportionately on Medicaid for health care, and because state Medicaid program funding for such transplants varies widely, many Medicaid recipients who cannot leave their home states to seek a transplant elsewhere are forced to do without. See *id.*

28. See Khauli, *supra* note 21, at 1231-32.

and other criteria to be placed on a waiting list. The potential for racially-biased decisionmaking exists at this stage, as much as at the organ allocation stage of the transplant process.²⁹ Although the UNOS allocation policies do not explicitly consider race, the emphasis on obtaining better results through close or exact tissue-matching helps to explain some of the disparities. Generally, donated organs are allocated to medically qualified candidates,³⁰ using a point system that takes into account patient proximity. The current policies also permit variances to the point system and allow alternative local organ distribution units to be established subject to OPTN approval.³¹ For kidneys, livers, and pancreata, potential recipients are ranked with points allocated to reflect different criteria, including blood type, histocompatibility, sensitivity of the patient to transplantation, degree of urgency, and waiting time.

29. In the southeastern United States, physicians refer African American patients for transplantation less frequently at the outset than white patients. See J. Michael Soucie et al., *Race and Sex Differences in the Identification of Candidates for Renal Transplantation*, 19 AM. J. KIDNEY DISEASES 414 (1992); see also Organ Procurement and Transplantation Network, 59 Fed. Reg. 46,482-86 (1994) (noting that current rules and proposed rules permit patients to be listed at multiple transplant centers, and inviting public comment on this policy); Sanfilippo et al., *supra* note 26, at 251 (concluding that patients with the financial resources to be listed at two or three transplantation centers have significantly shorter waiting times, and that multiple center listing discriminates against socioeconomically disadvantages transplant candidates). At the outset, physicians must decide whether to list a patient for transplant:

Experience indicates that if physicians are forced to choose among people in the allocation of scarce medical resources, they will choose people most like themselves and exclude those whom they deem "unworthy." Given that prosperous, white physicians probably do most of the selecting, there is a risk that the poor and minorities will have less chance of being selected than middle-class whites.

Developments in the Law—Medical Technology and the Law, 103 HARV. L. REV. 1519, 1630-31, 1636-37 (1990) [hereinafter *Medical Technology and the Law*] (citations omitted).

30. The health of the transplant patient, and the presence of other co-morbid factors besides the diseased organ itself, strongly correlate to the rate of transplantation. In a study analyzing the effect of co-morbid and sociodemographic factors on the rates of cadaveric kidney transplantation, the investigators noted that certain types of cardiac disease, diabetes, and other disease conditions were strongly associated with lower transplantation rates. See Daniel S. Gaylin et al., *The Impact of Comorbid and Sociodemographic Factors on Access to Renal Transplantation*, 269 JAMA 603, 607 (1993). However, the investigators also noted that the effects of sociodemographic factors were not mitigated by adjusting for co-morbid factors. "[T]his study demonstrates that sociodemographic indicators . . . are important predictors of access to transplantation: female sex, older age, race other than white, and low income are each associated with lower transplantation rates. These findings cannot be explained away as 'surrogate' effects related to case mix." *Id.* at 608.

31. See Organ Procurement and Transplantation Network, 59 Fed. Reg. at 46,482, 46,486-87. For example, alternative local organ distribution units might be permitted to develop interregional or intraregional organ sharing arrangements. See *id.*

In the case of kidney transplantation, UNOS has developed a prioritization system that relies heavily on human leukocyte antigen (HLA) matching to determine which patients will receive kidneys as they become available. This policy establishes point values for the quality of antigen matches, strongly favoring a perfect match.³² The current system significantly curtails access by African Americans to cadaveric kidneys because the likelihood of a perfect HLA match is very low when matching white donors with African American recipients.³³ The recent increase in African American donors will ameliorate this problem somewhat, but, as noted above, African Americans constitute a disproportionately large percentage of ESRD patients awaiting transplant. Increased kidney donation rates among minorities will not fully meet the needs of the African American patients at any time in the near future.

Some physicians and medical ethicists have expressed concerns about the criteria used to determine which patients will receive organs for transplantation. In particular, the emphasis on tissue matching for kidney allocation has attracted significant criticism. The preference for a perfect antigen match in kidney transplantation appears unnecessary in this era of highly efficacious anti-rejection drugs such as cyclosporine.³⁴ Physicians who question the heavy emphasis on perfect HLA matching suggest that the relatively small gains in successful outcomes do not justify the disparate impact of such policies on African American transplant candidates. On the other hand, a pure equity-based system (such as first-come, first-served) ignores other factors that will significantly impact transplant outcomes.³⁵ One group of commentators argue

32. *See id.*

33. *See* Gaston et al., *supra* note 27, at 1353 (noting that of six-antigen-matched recipients, initial reports documented fewer than 2% as African American, and that UNOS data confirms that African American patients received six-antigen-matched kidneys at one-tenth the rate of white patients).

34. *See id.* at 1354. *But see* Steve Takemoto et al., *Equitable Allocation of HLA-Compatible Kidneys for Local Pools and for Minorities*, 331 *NEW ENG. J. MED.* 760, 760 (1994) (noting that perfect six-antigen-matched kidneys have a significantly higher projected survival rate—20 years for 50% of those grafts still functioning at one year, compared to 6 years for “the average transplanted kidney”).

35. *See* Gaston et al., *supra* note 27, at 1354 (discussing the tension between equity and efficiency, and the flexibility of the term “medical criteria”). Commentators have observed:

The allocation of organs on a first-come, first-served basis is untenable for practical reasons of immune sensitization and blood group compatibility. Moreover, consideration of equitable access without anticipated outcome may

that the emphasis on HLA matching unjustly disfavors interracial transplantation, noting that white dialysis patients are more than twice as likely as African American patients to receive a kidney allograft.³⁶ They contend that enhanced transplant survival for perfectly matched kidneys does not necessarily outweigh other factors relevant to the selection process,³⁷ such as age and waiting time, and they suggest explicitly offsetting the racial disparities that result from the HLA matching system by, for instance, awarding points to African Americans to compensate for points accumulated by whites on the basis of HLA matching.³⁸

Although successful transplantation obviously represents the primary goal, the federal government directed OPTN to allocate organs “equitably among transplant patients” and according to “established medical criteria.”³⁹ An overemphasis on improving outcomes does not promote equitable allocation, but sometimes makes financial sense, as long as the transplanted kidney survives for at least five years. The costs associated with preserving and transporting perfectly matched kidneys to more distant locations may outweigh the medical costs saved through improved graft survival (by avoiding the need for retransplantation or return to dialysis).⁴⁰ However, some investigators have concluded that a system that combines partial matching with a regional hierarchical approach may prove to be more cost effective, in addition to reducing the disparate impact on minority transplant candidates created by the current preference for perfect matches.⁴¹

have an overall negative impact for all patients waiting for transplantation if the result is an increase in the number of organs lost to rejection or nonfunction.

Sanfilippo et al., *supra* note 26, at 252.

36. See Gaston et al., *supra* note 27, at 1352 (citing statistics of 8.3% for white patients versus 3.9% for African Americans). At the University of Alabama at Birmingham, which has a waiting list for kidney transplantation that is 65% African American, only one out of every 33 kidneys received as part of the perfect antigen match program has been slated for an African American patient. See *id.* at 1353.

37. See *id.* at 1354 (noting that, although a clear correlation exists between HLA match and outcome in transplantation from living donors, the benefits of a perfect HLA match in cadaveric transplants is less clear).

38. See *id.* at 1355. But see Takemoto et al., *supra* note 34, at 763 (objecting to such proposals because giving points at the outset based on skin color or ancestry is equally unjust for others who do not qualify).

39. See 42 U.S.C. § 274(b)(2)(A)(ii), (D) (1994).

40. See David W. Gjertson et al., *National Allocation of Cadaveric Kidneys by HLA Matching*, 324 NEW ENG. J. MED. 1032, 1032-36 (1991); see also Takemoto et al., *supra* note 34, at 760 (noting that only when a kidney survives more than five years is transplantation less expensive than maintenance dialysis).

41. See Takemoto et al., *supra* note 34, at 760, 763 (proposing a matching system that awards points for waiting time and for matches among the widely shared “HLA

The conflict between concerns about transplant efficacy and distributive justice continues in the area of organ transplantation. In 1996, the United States Public Health Service (PHS) announced a public forum to discuss proposed changes to policies for the allocation of livers and patient listing criteria for liver, kidney, and kidney/pancreas transplants.⁴² And under rules proposed in 1994, the OPTN would develop policies based on a variety of criteria to dictate the organ allocation process.⁴³ In addition to considering established medical criteria and length of time on the national waiting list, OPTN would be charged with the task of developing policies that more effectively take into account potential recipients whose immune system sensitization makes it difficult for them to receive organs, and it would thereby seek to minimize wastage of organs.⁴⁴ The proposed rules have not, however, been finalized.⁴⁵

C. Access to Prescription Drug Therapy

A review of the medical literature reaffirms what the overall disparity in health status between white and minority individuals already suggests: *race-related differences abound in access to and the utilization of a wide*

determinants" only, and concluding that such a system would obviate the need for much national kidney sharing while simultaneously improving equity of allocation and preserving maximal long-term kidney graft function).

42. See Meeting Notice, 61 Fed. Reg. 46,658 (1996); see also Organ Procurement and Transplantation Network, 61 Fed. Reg. 58,158 (1996) (soliciting additional comments on the allocation of human livers). UNOS organ allocation policies have been scrutinized by the General Accounting Office as well. See, e.g., GENERAL ACCOUNTING OFFICE, ORGAN TRANSPLANTS: INCREASED EFFORT NEEDED TO BOOST SUPPLY AND ENSURE EQUITABLE DISTRIBUTION OF ORGANS (1993).

43. See Organ Procurement and Transplantation Network, 59 Fed. Reg. 46,482 (1994) (proposing rules for listing transplant candidates on a nationwide computer network, for allocating organs, and for recordkeeping and reporting by organ procurement organizations and transplant hospitals).

44. See *id.* at 46,497. In discussing the proposal, the PHS acknowledged that organ allocation poses difficult issues:

For example, efforts to promote service to the sickest patients first versus those likely to survive the longest may conflict. Similarly, some policies intended to maximize transplant outcomes and based on sound scientific data may have adverse implications for one ethnic group in particular, or for residents of particular geographic areas.

Id. at 46,486.

45. See 62 Fed. Reg. 21,662, 21,707 (1997) (Semi-Annual Unified Regulatory Agenda) (providing no estimated finalization date).

variety of therapies, treatments, medications, and general preventive care. The following examples dealing with access to prescription drug therapy help to illustrate further the dimensions of the problem.

One study examined prescription drug therapy for HIV disease among patients presenting themselves for treatment at an urban AIDS clinic over almost a three-year period.⁴⁶ Using a set of medical eligibility criteria based on the patients' CD4+ cell counts at the time of referral to the clinic, the investigators found that African American patients were significantly less likely than white patients to have received antiretroviral therapy (63% of eligible white patients compared with only 48% of African American patients) or prophylactic therapy for *Pneumocystis carinii* pneumonia (82% of eligible white patients compared with 58% of eligible African American patients).⁴⁷ The study also examined these rates of drug utilization when adjusted for other patient factors such as income, insurance status, mode of HIV transmission, and place of residence. The results revealed that the addition of these variables to the equation failed to explain the racial disparity in rates of drug therapy.⁴⁸ Because of the barriers to care for young African Americans at risk for HIV,⁴⁹ and an apparent pattern of disparate treatment for those who have contracted the disease, the study's authors recommended a plan of early intervention using "culturally appropriate" methods and suggested that a community-based partnership between an academic medical center and the high-risk population might be effective.⁵⁰

Although relatively little data exists on the relationship between race and the use of prescription medications for children, one recent study found that, while approximately 79% of white children between the ages of one and five received a prescription medication when visiting a doctor, only 63% of African American children received prescriptions. For patients aged six to seventeen, 66% of white children received

46. See 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 (1994).

47. See *id.* at 764.

48. See *id.* at 764, 766 tbl.4.

49. The authors noted that African Americans, especially young inner-city males, "have historically neither sought nor had access to medical care, particularly preventive medical care . . . [and] are the group least likely to have a regular primary care physician." *Id.* at 767.

50. See *id.* at 767 (suggesting that community churches provide one avenue for interacting with the at-risk population and concluding that the increasing shift of HIV disease to poor urban communities "underscores the need for effective intervention to improve access to care"); see also Merrill Singer, *Confronting the AIDS Epidemic Among IV Drug Users: Does Ethnic Culture Matter?*, 3 AIDS EDUC. & PREVENTION 258 (1991).

prescriptions compared with 52% of African American children.⁵¹ Once it factored in additional predisposing variables, such as the child's age and the education level of the child's mother, and enabling variables, such as health insurance coverage and poverty status, the study concluded that, of children who visited the doctor at least once, African American children were approximately half as likely as white children to receive a prescription medication.⁵²

As with several of the other examples described above, the racial differences in rates of prescription medication access persisted even after adjusting for major variables—the study's author theorized that at least part of this variation may result from language barriers, cultural biases, or discrimination in treatment of minority patients.⁵³ The significance of these study results is not entirely clear. Although the investigators attempted to control for variables such as insurance coverage, such studies cannot adequately capture the nuances of the prescribing decision process. For example, some of the variations in rates of prescribing may arise from the physician's misperceptions about the patient's insurance coverage for prescription drugs. Even if insurance coverage is factored into the equation, the prescriber may still make incorrect assumptions about African American patients' likelihood of having prescription drug coverage, particularly if doctor and patient do not explicitly discuss insurance coverage during the consultation. And, for a variety of reasons, the parents of white children may be more insistent about obtaining a prescription to treat their children's illnesses. Furthermore, over-prescribing of drugs (particularly antibiotics) to treat simple childhood illnesses may cause long-term problems for individual patients and patient populations. Thus, although the study's conclusions point out an example of disparate care, the cause and significance of this disparity remains difficult to pinpoint. In fact, the reasons for individual prescribing decisions no doubt vary a great deal and may have no racial component once other explanations for these decisions receive consider-

51. See Beth A. Hahn, *Children's Health: Racial and Ethnic Differences in the Use of Prescription Medications*, 95 PEDIATRICS 727, 729 tbl.1 (1995).

52. See *id.* at 730 tbl.2.

53. See *id.* at 731. After controlling for the number of physician visits, need variables (*i.e.*, the health status of the child, the number of bed-days, and the number of reduced activity days), predisposing variables, and enabling variables, the study found that African American children were approximately 70% as likely as white children to receive a prescription medication. *Id.* at 730 tbl.2.

ation. Additional studies, designed to capture these variables more effectively, may help in the formulation of policies to address unexplained patterns of disparate prescribing.

D. *Diagnosis and Institutionalization of Mentally Ill Patients*

Evidence suggests that disparities in treatment between the races exist in the case of mental illness as well as diseases of the body. At the outset, several studies demonstrate that racial bias may affect the evaluation and diagnosis of mental illness.⁵⁴ In one study, the authors concluded that white therapists tended to rate their minority patients as more psychologically impaired than did African American therapists.⁵⁵ Another study suggested that therapists were more likely to conclude that minority patients diagnosed with psychotic or affective disorders were experiencing a chronic syndrome as opposed to an acute episode.⁵⁶ Yet another study found that therapists were more likely to misdiagnose African American and Hispanic patients as suffering from schizophrenia than white patients.⁵⁷

Once the treating psychiatrist has arrived at a diagnosis, some investigators have suggested that the race of the patient affects both the decision as to type of treatment and the long-term outcomes of such treatment. At the outset of treatment, psychiatrists assess whether the patient can be treated as an out-patient or needs institutionalization.⁵⁸ From 1960 to 1986, the ratio of minority to white patients under psychiatric care (per 100,000 in the population) remained the same, but

54. See, e.g., Jay C. Wade, *Institutional Racism: An Analysis of the Mental Health System*, 63 AM. J. ORTHOPSYCHIATRY 536, 541 (1993) (describing the results of various studies); K. Jenkins-Hall & William P. Sacco, *Effect of Client Race and Depression on Evaluations By White Therapists*, 10 J. SOC. & CLINICAL PSYCHOL. 322 (1991); Thomas W. Pavkov et al., *Psychiatric Diagnosis and Racial Bias*, 20 PROF. PSYCHOL.: RES. & PRAC. 364 (1989); Sukdeb Mukherjee et al., *Misdiagnosis of Schizophrenia in Bipolar Patients: A Multiethnic Comparison*, 140 AM. J. PSYCHIATRY 1571 (1983).

55. See Enrico E. Jones, *Psychotherapists' Impressions of Treatment Outcome as a Function of Race*, 38 J. CLINICAL PSYCHOL. 722 (1982).

56. See Wade, *supra* note 54, at 541.

57. See *id.* at 541. This disproportionate rate might be explained, in part, as follows:

The emphasis given to one item of information as opposed to another or the meaning attached to an incident is dependent on the beliefs, value judgments, and knowledge of the psychiatrist. If the clinician fails to take into account environmental circumstances, he or she may misjudge normal behavior as pathological.

Id. at 540-41.

58. See *id.* at 537 (describing the deinstitutionalization movement that began in 1955 and that resulted in a reduction in the number of state and county mental hospitals and a concurrent increase in private psychiatric hospitals and community mental health centers).

the number of minority inpatient admissions rose substantially compared with white inpatient admissions.⁵⁹ At the same time, although the number of outpatient facilities increased substantially, minority patients receiving treatment at these facilities did not increase in a corresponding fashion.⁶⁰ Finally, state and county hospitals function primarily to provide long-term care for patients for whom community-based outpatient services have been ineffective, and they continue to have the highest rates of minority patient admissions.⁶¹

One commentator theorizes that institutional racism contributes substantially to these trends.⁶² Although some of the differences in rates of public hospital institutionalization result from disparities in income between white and African American patients, the studies evaluating the assessment and diagnosis process suggest that unconscious racial biases might play a role as well. On the one hand, the decision to institutionalize a patient relates directly to the clinician's diagnosis and projected course for the patient's treatment. The studies described above suggest that a patient's race may subtly impact the clinician's diagnosis or decision about the appropriateness of a particular therapy. On the other hand, once the practitioner decides to place a patient in an institution for inpatient care, the patient's income and insurance status begin to play a role in directing that patient either to a public hospital or a private facility. The latter problem could be addressed by increasing insurance coverage for mental health services and redoubling efforts to build outpatient clinics in inner-city and rural areas, but addressing racial bias at the assessment and diagnosis level seems to present a more intractable difficulty.

59. *See id.* at 538 (noting that admissions for psychiatric care in general hospitals rose 37% for minority patients and only 17% for white patients, and that admissions to private hospitals rose 81% for minority patients and only 46% for white patients).

60. *See id.* (noting that, from 1969 to 1986, there was a 52% increase in the utilization of outpatient psychiatric clinics by white patients, but only a 36% increase in minority-race patient care at these facilities).

61. *See id.* at 538-39 (noting that state and county mental hospitals admit minority patients at the rate of 90 per 100,000 in the general population, whereas the admission rate for white patients is just 30 per 100,000).

62. *See id.* at 537, 539 (describing the "insensitivity to cultural and language differences and . . . lack of interest on the part of major decision makers" that led to inadequate development of community mental health facilities to serve minorities, and noting the lack of mental health curricula designed to prepare clinicians to meet the "psychosocial" needs of minorities).

E. Minority Patient Populations in Clinical Trials

Certain clinical research practices play a role in perpetuating racial (and gender) inequities in health care. For instance, new drug trials and other types of biomedical research frequently fail to include subjects from minority groups. The desire to streamline such research in order to produce results that are clearly and easily interpretable has led investigators to prefer homogenous patient populations for virtually all studies. Before the National Institutes of Health (NIH) issued a directive in 1990, investigators almost uniformly tested new chemical entities only on white male subjects, excluding women and members of other races.⁶³ The 1990 policy requires that applicants for clinical research grants either include women and minorities in their studies or provide a “clear and compelling rationale” for failing to include these groups.⁶⁴ The NIH mandate finally recognized that using a homogenous research population provides little therapeutic benefit for persons outside that population after a treatment becomes generally available. The Food and Drug Administration (FDA) also has addressed the issue, through modifications of product approval guidelines that apply whether or not the clinical trials received some NIH funding,⁶⁵ and more recently in

63. Such studies frequently exclude children as well. Only 42% of drugs that are routinely used to treat pediatric patients have been tested on children in clinical trials. A new FDA regulation, issued in August 1997, will attempt to increase the clinical trial testing of drugs on pediatric patients where it is practical to do so. See Robert Pear, *President to Order Drug Makers to Conduct Pediatric Studies*, N.Y. TIMES, Aug. 13, 1997, at A17; see also 62 Fed. Reg. 43,900 (1997) (to be codified at 21 C.F.R. pts. 201, 312, 314, 601) (requiring manufacturers of drugs that are widely used in pediatric populations but that do not contain adequate labeling information for these populations to submit evidence, in certain circumstances, to support dosage and administration directions for these patients).

64. See Policy for Inclusion of Women and Minorities in Clinical Research Study Populations, available at National Institutes for Health Site (visited Mar. 10, 1998) <<http://www.nih.gov/niams/grants.sdrc.www.htm#III.D>> .

65. See 60 Fed. Reg. 46,794 (1995) (to be codified at 21 C.F.R. pts. 312, 314) (proposing rule that would require manufacturers seeking new drug approval to submit safety and efficacy data reflecting breakdown according to gender, age, and racial subgroups (in addition to aggregate data), but that would not require inclusion of these groups in clinical trials); 58 Fed. Reg. 39,406, 39,408 (1993) (summarizing a guideline that concludes that the exclusion of women from early clinical trials is not medically necessary because the risk of fetal exposure can be minimized by patient behavior and laboratory testing); see also Lars Noah, *Constraints on the Off-Label Uses of Prescription Drug Products*, 16 J. PROD. & TOXICS LIAB. 139, 139-47 (1994) (describing the prevalence of off-label prescribing by physicians, necessitated by limitations in clinical testing, and the FDA's regulatory responses).

its reform bill.⁶⁶

Although researchers offer a number of possibly valid reasons for excluding women from clinical studies (including concerns about harm to fertile women who may become pregnant, and complications posed by the female hormonal cycle),⁶⁷ no such justifications exist for excluding African Americans and other minorities from biomedical research populations. On the contrary, scientific research has documented the wide variation of the pharmacokinetic effects of drugs across racial and ethnic lines.⁶⁸ One cannot, therefore, safely extrapolate from data based on white males to others in the population.⁶⁹ In fact, the risks to women and minorities who make an informed choice to participate in closely monitored and controlled research are more justifiable than the greater risks associated with the use of approved drugs or treatments, untested in these populations, on a widespread basis after testing and FDA approval. Furthermore, diseases that affect a

66. See 143 Cong. Rec. H10,452-56 (daily ed. Nov. 9, 1997) (House statement on S. 830 § 115(b)). The proposal would amend the Food, Drug, and Cosmetic Act, 21 U.S.C. § 355(b)(1), to read as follows: "The Secretary shall, in consultation with the Director of the National Institutes of Health and with representatives of the drug manufacturing industry, review and develop guidance, as appropriate, on the inclusion of women and minorities in clinical trials"

67. See Joan W. Scott, *How Did the Male Become the Normative Standard for Clinical Drug Trials?*, 48 FOOD & DRUG L.J. 187, 187-88 (1993) (describing two contradictory assumptions—that women are identical to men so that female participation in drug trials is unnecessary, and that women are so unlike men that female participation in drug trials would destroy the purity of the experiment—that have contributed to this phenomenon).

68. See, e.g., Craig K. Svensson, *Representation of American Blacks in Clinical Trials of New Drugs*, 261 JAMA 263 (1989) (concluding that investigators do not adequately account for racial differences as a source for variability in drug research results, and that insufficient data exist to assess the safety and efficacy for the African American population of many drugs currently on the market); Paul Cotton, *Is There Still Too Much Extrapolation From Data on Middle-Aged White Men?*, 263 JAMA 1049 (1990) (same); Hong-Hao Zhou et al., *Racial Differences in Drug Response*, 320 NEW ENG. J. MED. 565 (1989) (concluding that Chinese men have greater sensitivity than white men to the effects of the drug propranolol on heart rate and blood pressure); *The 1984 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure*, 144 ARCHIVES INTERNAL MED. 1045, 1054 (1985) (noting that, although African Americans suffer from a higher incidence of hypertension, ACE inhibitors are less effective in treating this condition in African Americans than in the white population).

69. See Rebecca Dresser, *Wanted: Single, White Male for Medical Research*, HASTINGS CTR. REP., Jan./Feb. 1992, at 24, 26 (describing a study in which the "normal" dosage of lithium for white males was found to be frequently toxic for African American patients).

disproportionate number of women or minorities historically have received low research funding priority.⁷⁰ Some critics have suggested that decisions to exclude women and minorities from biomedical research reflect an assumption that white males most deserve the benefits that this research produces.⁷¹ To the extent that the NIH and FDA policies do not mandate some diversification in research populations, it is important that investigators alter their protocols to reflect these concerns.

F. Summary

The number of published articles on medical topics utilizing categories of race and ethnicity or referring to patterns of "racism" has risen dramatically in recent years.⁷² But epidemiologists, concerned about the use of race and ethnicity as variables in health surveillance, have lamented the fact that "no clear consensus exists regarding the measurement and use of these concepts."⁷³ Participants in a recent workshop on these issues sponsored by the Centers for Disease Control and Prevention (CDC) emphasized the importance of supplementing racial and ethnic information with data on socioeconomic and cultural variables whenever relevant.⁷⁴ Any attempt to remedy disparities in the delivery of health care services must confront the possibility of racism as a motivating factor in treatment decisions. Some commentators have concluded that the health care system as well as many of its individual providers perpetuate racist attitudes.⁷⁵ An editorial accompanying the

70. *See id.*

71. *See id.* at 27-28.

72. *See* Trevor A. Sheldon & Hilda Parker, *Race and Ethnicity in Health Research*, 14 J. PUB. HEALTH MED. 104, 106 tbl.1 (1992). The authors used a search of Medline from 1985 to 1990 to illustrate their point. In 1985, a total of 879 publications mentioned "race" in their titles or abstracts, and only one article referred to "racism." By 1990, these numbers had risen to 1372 and 20 respectively.

73. *See* Reuben C. Warren et al., Editorial, *The Use of Race and Ethnicity in Public Health Surveillance*, 109 PUB. HEALTH REP. 4 (1994).

74. *See id.* at 5; *see also* Lisa C. Ikemoto, *The Fuzzy Logic of Race and Gender in the Mismeasure of Asian American Women's Health Needs*, 65 U. CIN. L. REV. 799, 807-09 (1997) (arguing that using white males as the standard by which to compare the health of women and minority groups perpetuates the tendency to view the health of white male groups as primary and to disregard the social and economic implications of the statistics attributed to the female and minority groups).

75. *See* Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy!*, 15 ST. LOUIS U. PUB. L. REV. 191, 231 (1996). Professor Randall concludes that the disparate care received by African American patients constitutes a more explicit and avoidable kind of racism: "Eurocentric bioethical principles such as autonomy, beneficence, and informed consent . . . leave considerable room for individual judgment by health care practitioners. . . . In a racist society (such

HCFA study considered the complexities inherent in formulating a response by the medical community to the evident racial inequities in the delivery of health care services. Dr. Jack Geiger, of the City University of New York Medical School, concluded that the “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.”⁷⁶

Because of the complex nature of health care decisionmaking, however, attributing disparities in health care to racism may not accurately portray the whole of the problem. Racist attitudes undoubtedly exist at the level of the individual provider, in some cases, and certain institutional policies may have a disparate impact on minorities as well. But other contributing factors, such as the overall health status of the patient, the stage of disease at which treatment is sought, patient income, and insurance status, inevitably complicate the picture.⁷⁷ Thus, disparities in a pattern of treatment for similar conditions depending on the race of the patient may result from factors other than racism.⁷⁸ Certainly such disparities may provide evidence of conscious or unconscious racism within the health care system, but as Professor Randall Kennedy recently has pointed out, “disparity” and “discrimina-

as ours), the judgment is often exercised in a racist manner.” *Id.*

76. See Geiger, *supra* note 10, at 816.

77. Professor Randall acknowledges that factors in addition to race—such as income, insurance status, and education—affect access to health care. See Randall, *supra* note 75, at 218-19 (noting that homelessness, violence, drugs, and the inability of managed care to provide “culturally relevant care” all adversely affect the health status of African Americans). In the case of epidemiological studies using race or ethnicity as variables:

Differences which are described as racial are often social in origin and reflect the key role of social conditions, although often the studies are too poorly designed to distinguish ethnic group from other confounding variables such as social class.

Sheldon & Parker, *supra* note 72, at 106.

78. For example, one recent study found that decisions regarding the course of care for terminal illness tend to follow different patterns depending on the region of the country in which the patient resides. According to the study, elderly patients in Miami and New York City are more likely to spend the final days of a terminal illness in a hospital intensive care unit than patients in the Western states, who were more likely to die at home. See George Anders, *ZIP Code Is a Key to Course of Terminal Care*, WALL ST. J., Oct. 15, 1997, at B1.

tion” are not synonymous.⁷⁹ A careful evaluation of the statistics providing evidence of these disparities, including an analysis of contributing factors apart from racism, is essential to crafting policies that will deal effectively with the problem.

A variety of unconscious, and largely unprovable, factors may affect health care decisions for minority patients. For example, treating physicians may “give up” earlier on their African American patients, either by concluding that certain treatments will be unavailing or by resorting to drastic solutions for those patients who present for care late in the disease process. Health care providers sometimes may decide that simplicity or utility more readily dictates a decision to resort, for example, to lower limb amputation in the case of diabetic complications, rather than leg-sparing vascular surgery to improve circulation, or to pursue less aggressive, non-surgical therapies (such as medication and dietary changes) in the case of coronary illness among African American patients.⁸⁰ Physicians’ treatment decisions may reflect unstated prejudices—negative or pessimistic assumptions about their African American patients’ family support networks, dietary practices, or adherence to recommended post-treatment care regimens. In this sense, unconscious racism may be one factor that perpetuates the cycle of poorer health among African Americans as compared with the white population in this country.

III. RESPONSES TO THE PROBLEM OF DISPARITIES IN HEALTH CARE

In terms of health status, an enormous gulf exists between white and African Americans. As the above examples demonstrate, this difference exists not just with regard to a few specified diseases, but instead spans a wide variety of conditions and treatment choices. The solutions discussed in the following sections represent some of the options that might prove useful in undoing the effects of racial disparities in health

79. See RANDALL KENNEDY, *RACE, CRIME, AND THE LAW* 9 (1997). Professor Kennedy eloquently criticizes the “intellectual sloppiness” surrounding the debate about racism in law enforcement. His words apply equally well to the health care context:

A proper appreciation for words is not the only casualty of the intellectual sloppiness that has impeded analysis of racial issues in the administration of criminal law. Another is the proper interpretation of statistics. . . . Too often . . . activists . . . (along with journalistic and scholarly supporters) automatically insist, simply on the basis of observable racial disparities, that officials are engaged in making invidious racial discriminations. They seem unaware that a racial disparity is not necessarily indicative of a racial discrimination. A disparity is often evidence of discrimination. But one must keep in mind that a racial disparity may stem from causes other than disparate treatment.

Id. (footnotes omitted).

80. See Part II.A *supra* (discussing HCFA study).

care.⁸¹ Of course, even if it were possible to achieve perfect equity in health care, there is no guarantee that the races would enjoy equal health statuses. Equitable provision of services represents just one required component in the drive to improve the health of various minority patient populations. The formulation of appropriate health policy, particularly as it implicates race, represents a complex task, and no single solution will adequately address the various imbedded issues.⁸² To further complicate matters, the recent political and judicial condemnation of affirmative action efforts⁸³ suggests that health care policies designed to benefit minority groups may encounter substantial opposition.⁸⁴

This Part provides an overview of existing legal remedies that may address particular types of health care disparities or discriminatory practices, and then it explores potential approaches for preventing such disparities in the future. The discussion concludes that legal remedies will likely prove unavailing in many disparate care contexts and suggests that prospective approaches, such as education and governmental and institutional oversight, may prove more effective in reducing the incidence of disparate health care.

A. *Retrospective Remedies*

As the medical community and the federal government consider steps to prevent future racial disparities in the delivery of health care services, victims of existing inequities may wish to pursue legal remedies. The remedies currently available to individual plaintiffs offer only a limited

81. Taking a broad perspective, one commentator has observed:

[T]here are positive, lasting steps we can take to give all Americans equity in health care. There are powerful forces we can use to overcome racism—an equitable health care system and the formation of a culture of character, a culture that places a high priority on personal responsibility, mutual respect, and community service.

Sullivan, *supra* note 2, at 2674.

82. As one group of commentators put it, "Large, complex problems do not lend themselves to monolithic solutions" *Medical Technology and the Law*, *supra* note 29, at 1625.

83. See, e.g., *Taxman v. Bd. of Educ. of Piscataway*, 91 F.3d 1547 (3d Cir. 1996), *cert. granted*, 117 S. Ct. 2506 (1997), *cert. dismissed*, 118 S. Ct. 595 (1997); *Hopwood v. Texas*, 78 F.3d 932 (5th Cir. 1996), *cert. denied*, 116 S. Ct. 2580 (1996); Alison Mitchell, *Clinton Feels Sure-Footed on the Tightrope of Race*, N.Y. TIMES, June 16, 1997, at B10; Symposium, *Representing Race*, 95 MICH. L. REV. 723 (1997).

84. See Velvet G. Miller & Janis L. Curtis, *Health Care Reform and Race-Specific Policies*, 18 J. HEALTH POL., POL'Y & L. 747, 748 (1993).

and disappointing range of options. The federal government also can pursue several statutory remedies against offending institutions that receive federal funds. This section will explore statutory and constitutional litigation as a response to the problem of disparate health care for racial minorities, and it will suggest potential avenues for reform.

1. Remedies Under Title VI

Title VI of the Civil Rights Act of 1964⁸⁵ provides the most promising federal statutory avenue for dealing with racial discrimination in health care delivery. In enacting Title VI, Congress prohibited any entity that opts to receive federal financial assistance from discriminating on the basis of race in providing goods or services to the intended beneficiaries of the federal program.⁸⁶ “Federal financial assistance” includes Medicare and Medicaid funds, and, because nearly every hospital and nursing home in the United States receives such assistance, Title VI applies to the majority of all health care facilities.⁸⁷ Regulations promulgated under Title VI include a requirement that federally-funded programs provide contractually-binding assurances that they will adhere to Title VI regulations,⁸⁸ and that such programs file “compliance reports” with the Office of Civil Rights at HHS documenting the quantity and type of services provided to minorities.⁸⁹ Title VI has been used to contest the closing of hospitals where the decision to close reduces access to care for minorities.⁹⁰ Plaintiffs also have used Title VI successfully to condemn limitations on Medicaid payments that were facially neutral but disproportionately impacted minority program beneficiaries.⁹¹

85. Pub. L. No. 88-352, 78 Stat. 252 (codified at 42 U.S.C. §§ 2000d - 2000d-4 (1994)).

86. See 42 U.S.C. § 2000d (1994) (“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.”).

87. See 45 C.F.R. § 80 app. A (1996) (listing grant programs that provide other “federal financial assistance” triggering Title VI requirements); *United States v. Baylor Univ. Med. Ctr.*, 736 F.2d 1039, 1046 (5th Cir. 1984) (noting that virtually every court that has considered the issue has concluded that receipt of Medicare and Medicaid funds constitutes federal financial assistance triggering Title VI); *NAACP v. Med. Ctr., Inc.*, 657 F.2d 1322, 1329 (3d Cir. 1981); see also Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn't Be So Easy*, 58 *FORDHAM L. REV.* 939, 945-46 (1990).

88. See 45 C.F.R. § 80.4 (1996).

89. See *id.* § 80.6(b).

90. See, e.g., *NAACP*, 657 F.2d 1322; *Bryan v. Koch*, 627 F.2d 612 (2d Cir. 1980).

91. See, e.g., *Linton v. Comm'r of Health & Env't.*, 779 F. Supp. 925, 934-35 (M.D. Tenn. 1990) (state policy limiting number of nursing home beds available for

The United States Supreme Court has held that Title VI prohibits both intentional discrimination and disproportionate adverse impact.⁹² The statute is enforced mainly by the administrative agencies that provide the federal funding, and the regulations implementing Title VI grant to federal agencies the power to terminate funding to any recipient that violates this nondiscrimination requirement.⁹³ The implementing regulations specifically state that facially neutral policies that have a disproportionate negative impact on racial minorities violate Title VI, whether or not any discriminatory intent exists.⁹⁴ Administrative agencies have consistently concluded that Title VI and its regulations prohibit policies that have a disproportionate adverse impact on minorities.⁹⁵

When the policy in question disproportionately affects minority patients, and the plaintiffs can prove disparate impact,⁹⁶ the burden then

Medicaid patients violates Title VI).

92. See *Lau v. Nichols*, 414 U.S. 563 (1974). "Simple justice requires that public funds, to which all taxpayers of all races contribute, not be spent in any fashion which encourages, entrenches, subsidizes, or results in racial discrimination." *Id.* at 569 (quoting 110 CONG. REC. 6543 (1963) (statement of Sen. Humphrey quoting from President Kennedy's message to Congress, June 19, 1963)). The Court subsequently held that, although Title VI itself prohibits only intentional discrimination, the implementing regulations may redress disproportionate adverse impact claims. See *Alexander v. Choate*, 469 U.S. 287, 293 (1985). Disparate impact is defined as "unjustified practices that are facially neutral, yet disproportionately affect minorities." Amy Jurevic, *Disparate Impact Under Title VI: Discrimination, By Any Other Name, Will Still Have the Same Impact*, 15 ST. LOUIS U. PUB. L. REV. 237, 241 (1996).

93. See 42 U.S.C. § 2000d-1 (1994) (providing an opportunity for a hearing prior to termination of federal financial assistance based on a violation of Title VI or its implementing regulations). The administrative hearings are subject to judicial review under 42 U.S.C. § 2000d-2.

94. See 45 C.F.R. § 80.3(b) (1996) (prohibiting activities that impair agency objectives with regard to race, color, or national origin, and those that result in a disproportionate impact on a group).

95. See, e.g., *Organ Procurement and Transplantation Network*, 59 Fed. Reg. 46,482-83 (1994) (to be codified at 42 C.F.R. pt. 121) (concluding that Title VI applies to organ procurement organizations and transplant hospitals that receive federal funds); see also *Watson*, *supra* note 87, at 948. Title VI regulations prohibit "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." 45 C.F.R. § 80.3(b)(1)(vii)(2).

96. See *Stan Dorn et al., Anti-Discrimination Provisions and Health Care Access*, 20 CLEARINGHOUSE REV. 439, 441 & n.27 (1986) (describing the use of "testers"—people pretending to be patients, who share common traits or symptoms except for their race—to prove that patients of a particular race receive different treatment).

shifts to the defendant to justify the policy. In a case challenging the closure of a municipal hospital under Title VI,⁹⁷ the United States Court of Appeals for the Second Circuit required only that the policy be rationally related to a legitimate need.⁹⁸ In another case, a different court held that once the plaintiffs made out a prima facie case of discrimination, the defendant recipient of federal funds must demonstrate that its policy or decision was rational and that the decisionmaking process was lawful.⁹⁹ The court held that the usual deference accorded to agency decisionmaking was not required where the state agency was a defendant in a discrimination case.¹⁰⁰

In the hospital context, a variety of facially neutral policies may have a disproportionate impact on racial and ethnic minorities seeking treatment. Examples include practices such as admitting only patients who have treating physicians with staff privileges at the hospital, requiring substantial deposits before admission for inpatient care, refusing to deliver babies if their mothers have not received a specified amount of prenatal care, and creating barriers to the admission of Medicaid patients.¹⁰¹ Many minority patients do not regularly receive care from a physician with hospital privileges, many of these patients do not have the financial resources to pay a deposit for care, many minority women do not receive adequate prenatal care, and minorities comprise a large percentage of Medicaid patients.¹⁰² Each of these policies can

97. See *Bryan v. Koch*, 627 F.2d 612 (2d Cir. 1980)

98. See *id.* at 617-19 (implicitly applying this standard). The plaintiffs argued for a higher standard, requesting that the court determine whether the hospital closing was "necessary to achieve legitimate objectives" and that the court uphold the closing only if the city's objectives could not be accomplished by other means that had a less disproportionate adverse effect on the plaintiffs. See *id.* at 618; see also *NAACP v. Med. Ctr., Inc.*, 657 F.2d 1322, 1336 (3rd Cir. 1981) (requiring that a hospital relocation serve a legitimate bona fide interest, and suggesting a rational relationship test to evaluate the defendants' justification under Title VI).

99. See *Jennings v. Alexander*, 715 F.2d 1036, 1044 (6th Cir. 1983), *rev'd sub nom. Alexander v. Choate*, 469 U.S. 287 (1985). The plaintiffs challenged the state's Medicaid policy that limited the number of inpatient hospital days per year covered by Medicaid, arguing that such a policy would deter handicapped Medicaid recipients from using hospital services early in the year. See *id.* at 1042-44. The case was filed under section 504 of the Rehabilitation Act, but its disparate impact analysis has been interpreted as analogous to that for Title VI cases because its statutory language is virtually identical. See *id.* at 1040-41; see also *Jurevic*, *supra* note 92, at 246.

100. See *Jennings*, 715 F.2d at 1044.

101. See *Watson*, *supra* note 87, at 941-42; see also *Dorn et al.*, *supra* note 96, at 441 (describing other examples of such policies, including not having physicians on staff who accept Medicaid patients and refusal to participate in programs to finance care for low-income patients who do not qualify for Medicaid).

102. See *Watson*, *supra* note 87, at 941 nn.15-18. One commentator has argued that the Oregon Medicaid List of Prioritized Health Services, which ranks diseases and their treatments in order of importance, is subject to challenge under Title VI. The Medicaid

be justified based on concerns about cost-limitation or liability; yet each policy also excludes a disproportionate number of minority patients from obtaining the hospital care they need. Title VI provides one avenue for attacking these “subtle barriers” to care.¹⁰³

Even so, Title VI only prohibits those inequities that arise from the application of facially neutral policies—it does not prohibit racial inequities whenever they occur. Thus, the difficulty lies with pinpointing the policy creating the disproportionate impact. HCFA could argue, on the basis of recent statistics, that discriminatory criteria in the health care decisionmaking process impede the Medicare program’s goal of providing consistent, high quality care to all beneficiaries. HCFA will find it difficult, however, to identify precisely which policies are causing the disproportionate impact. Similarly, the individualized medical decisionmaking that occurs in the contexts of mental illness diagnosis and drug prescribing is unlikely to result from institutional mandates or policies, facially neutral or otherwise; thus HCFA will find such decisions difficult to challenge under Title VI. In contrast, federal agencies can more readily identify policies causing disparate racial impact in the allocation of kidneys for transplantation and in protocols for clinical research, making these types of medical decisions more readily subject to challenge when a pattern of disparities emerges.

Thus, administrative enforcement of Title VI fails to address or capture the effects of actions of individual physicians who deliver care at institutions that are required to comply with the statute. Physicians with staff privileges at hospitals and nursing homes who deliver care in a discriminatory manner, either consciously or unconsciously, presumably are not adhering to any formal institutional policy. In such a situation, the agency will find it difficult to lay blame at door the of the institution and revoke its federal funding. A standard holding the provider institution responsible for its staff physicians’ discriminatory conduct when the institution knows or has reason to know that a physician was providing care in a discriminatory manner might represent a partial response to this problem. Ultimately, however, this solution is

funds available cover services ranked up to approximately #600, and fail to cover treatments for obesity. Since 48% of African American women are clinically obese, compared with 32% of white women, and since obesity increases the risk for a variety of other serious diseases, the failure to cover obesity treatment disproportionately burdens African American women. See Jurevic, *supra* note 92, at 253-55.

103. See Watson, *supra* note 87, at 941.

unsatisfactory, because it does not directly address the problem of the hidden, unconscious racist assumptions that sometimes affect health care decisions. As long as physicians can offer alternative explanations for treatment decisions, conduct of this sort appears to be out of the reach of legal remedies.

Individual litigation under Title VI offers less promise. In *Guardians Association v. Civil Service Commission*,¹⁰⁴ the Supreme Court held that a private right of action under Title VI exists only in certain limited circumstances.¹⁰⁵ In a private suit, the plaintiff may secure equitable relief if able to prove intentional discrimination. The Court did not, however, clearly answer the question of whether similar relief might be available where the plaintiff can only prove the disparate impact of a facially neutral policy.¹⁰⁶ In one earlier case, the Supreme Court held unanimously that a school district's facially neutral policy violated Title VI.¹⁰⁷ The Court has since cited this decision for the proposition that Title VI prohibits policies that create a disproportionate adverse impact on minorities, although the justices were not unanimous in reaching this more general conclusion.¹⁰⁸ In a more recent decision, the Court interpreted *Guardians Association* to hold that Title VI itself prohibits only intentional discrimination, although it also noted that the regulations implementing Title VI provide a basis for a disparate impact claim.¹⁰⁹ Even so, one commentator has suggested that private plaintiffs "can prevail upon a showing of disproportionate adverse impact without proof of intent to discriminate as long as they are careful to allege a violation of the Title VI regulations."¹¹⁰

104. 463 U.S. 582 (1983).

105. See *id.* at 593-95 (plurality opinion). Victims of racial discrimination cannot, of course, seek termination of federal financial assistance to the offending institution, but can sue to recover damages and equitable relief. Victims may also file an administrative complaint with the Office of Civil Rights at the Department of Health and Human Services. See 45 C.F.R. § 80.7(b) (1996).

106. See *Guardians*, 463 U.S. at 642-45; see also 1 RODNEY A. SMOLLA, FEDERAL CIVIL RIGHTS ACTS 8-9 to 8-10 (3d ed. 1994).

107. See *Lau v. Nichols*, 414 U.S. 563 (1974).

108. The majority opinion in *Lau*, to which five justices subscribed, relied on the language of the statute's implementing regulations that expressly prohibits practices that have a discriminatory effect, and imputed the express prohibition in the regulations to the statute itself. See *id.* at 566-68. Other justices concluded instead that the regulations were the product of valid administrative action. See *id.* at 570-71 (Stewart, Burger, & Blackmun, J.J., concurring); see also Watson, *supra* note 87, at 949-50 (discussing *Lau*).

109. See *Alexander v. Choate*, 469 U.S. 287, 293-94 (1985).

110. Watson, *supra* note 87, at 953. Professor Watson noted that the question of what relief Title VI plaintiffs can obtain remains unsettled, as do issues surrounding evidentiary burdens. See *id.* at 954.

Even if private plaintiffs need not establish discriminatory intent, a disparate impact claim may remain difficult to establish. Lower courts faced primarily with challenges to hospital closings and relocations have utilized a rational basis test, which makes defending Title VI discrimination claims relatively easy for health care entities; courts have upheld such actions even where plaintiffs have suggested less discriminatory alternatives.¹¹¹ As in cases brought by the government, the lack of rigorous scrutiny in Title VI litigation creates significant barriers to challenging policies that have a disproportionate impact on minorities. Plaintiffs will prevail under this standard only if they can prove that the challenged policies are arbitrary and fail to advance any legitimate purpose.

One commentator has suggested strengthening the standard of review for Title VI challenges; under the proposed approach, the defendant would have to demonstrate that the challenged policy "significantly" furthers an important purpose, and courts would give more consideration to the availability of less discriminatory alternatives as proof that the interests behind the challenged policy are insufficient to justify its disparate racial impact.¹¹² Unless the courts accept such an approach, however, administrative agencies will shoulder most of the responsibility for enforcing Title VI in the health care arena. To date, they have not done so.

2. *Equal Protection Theories*

In addition to statutory rights of action, patients who have suffered disparate treatment based on their race might consider an equal

111. See *NAACP v. Med. Ctr., Inc.*, 657 F.2d 1322, 1333-34, 1366-67 (3d Cir. 1981) (noting that, even if plaintiffs had presented a prima facie case of disparate impact, defendants need only present evidence of an acceptable reason and are not required to show absence of discriminatory motive); *Bryan v. Koch*, 627 F.2d 612, 617-19 (2d Cir. 1980) (holding that Title VI does not require a federal fund recipient to consider alternatives to the closing of a public health facility if the criteria used to make the decision are reasonably related to a goal such as cost savings). One judge in *Bryan* urged the court to engage in a two-pronged evaluation of the agency action, first examining the process by which the decision was reached and then inquiring into the substantive merits of the decision. See *id.* at 623 (Kearse, J., concurring in part and dissenting in part).

112. See *Watson*, *supra* note 87, at 976; see also *Jurevic*, *supra* note 92, at 264 (proposing that, once the plaintiff makes a prima facie case of disparate impact, the impact must be sufficiently justified).

protection challenge. In its current formulation, however, equal protection analysis may not provide a workable remedy for disparities in health care delivery. First, plaintiffs will find it difficult to demonstrate the necessary “state action” if their complaint centers around the decision of a provider not to pursue a particular course of treatment. In many of the contexts presented above—Medicare services, kidney allocation, access to prescription drugs, institutionalization for mental illness, and clinical trials—plaintiffs will find it difficult to prove state action.¹¹³ The receipt of federal funding triggers statutory obligations but does not necessarily constitute state action.¹¹⁴

Second, plaintiffs cannot easily prove discriminatory intent, particularly in the contexts of organ allocation and decisions to utilize particular medical treatments. A host of “confounding variables” including, perhaps, unconscious racial stereotyping, makes the intent of the medical decisionmaking difficult to discern. Health care providers making individualized medical decisions concerning, for example, whether to utilize a sophisticated coronary procedure for one patient or whether to prescribe a dose of antibiotics for another, can always offer a medical justification for their decision, even if the decision in fact arose from a conscious or unconscious reaction to the patient’s race. Those involved in the organ allocation process likewise can explain in medical terms why a particular patient is not a good candidate for a transplant (and thus should not be wait-listed), although the medical explanation may

113. One group of commentators has speculated that, in the organ transplantation context, the UNOS allocation policies constitute state action for purposes of requiring due process because the contract between the privately-run corporation and the federal government arguably creates an adequate nexus. *See Medical Technology and the Law*, *supra* note 29, at 1638 (suggesting that the relationship between UNOS, OPTN, and the federal government might make UNOS a de facto state actor). The authors concluded, however, that the recent trend in state action cases, together with the enormous burden that due process requirements would impose on the organ allocation process, makes it highly unlikely that the Supreme Court would deem UNOS a state actor. *See id.* at 1640.

114. *See, e.g.,* *Blum v. Yaretsky*, 457 U.S. 991, 1011-12 (1982) (finding no state action by nursing home even though the bulk of its activities were financed by state Medicaid program); *see also* *Rendell-Baker v. Kohn*, 457 U.S. 830, 840-41 (1982) (finding no state action by a private school even though the bulk of its funding was received from the state); *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163, 166-67 (1972) (holding that pervasive regulation of an activity does not by itself constitute state action). Similarly, claims based on a denial of due process under the Fifth and Fourteenth Amendments will also likely fail for want of state action. *See, e.g.,* *White v. Moses Taylor Hosp.*, 763 F. Supp. 776, 785-86 (M.D. Pa. 1991) (concluding that a hospital’s receipt of funds under the Hill-Burton Act does not constitute state action); *see also* *Loh-Seng Yo v. Cibola Gen. Hosp., Inc.*, 706 F.2d 306, 308 (10th Cir. 1983); *Modaber v. Culpepper Mem’l Hosp.*, 674 F.2d 1023, 1026 (4th Cir. 1982); *Newsom v. Vanderbilt Univ.*, 653 F.2d 1100, 1115 (6th Cir. 1981); *Hodge v. Paoli Mem’l Hosp.*, 576 F.2d 563, 564 (3d Cir. 1978).

include psychosocial factors as well.¹¹⁵ If a plaintiff cannot prove that the institutional provider intended to discriminate, courts will simply examine whether a rational basis exists to justify its actions, rather than review the actions under a strict scrutiny standard.¹¹⁶

Thus, as with private statutory rights of action under Title VI, constitutional challenges seem unavailing. No matter how compelling the evidence of racial inequities in the health care context, nothing convincingly suggests a pattern of widespread *intentional* discrimination. Clearly, discrimination can exist without proof of invidious intent, but not all documented inequities across racial lines constitute discrimination.¹¹⁷ "Intent" in the equal protection context embodies ideas of willfulness and morally reprehensible motivation. Even so, disparate health treatment decisions that do not result from poor preventive care, or from a patient's presenting with a more acute condition, may well arise from unconsciously biased decisions on the part of health care professionals. Given these complexities, it seems appropriate to reconsider the current equal protection analysis requirement that plaintiffs prove intentional discrimination.¹¹⁸

115. See, e.g., *Medical Technology and the Law*, *supra* note 29, at 1636 ("[F]actors that are admittedly relevant in determining whether a particular patient will be [a] good transplant recipient, such as occupation, educational level, and family environment, might be used as yardsticks of social worth or means by which unconscious stereotypes influence patient selection.").

116. See, e.g., *Washington v. Davis*, 426 U.S. 229, 244-45 (1976) (holding that plaintiff was required to prove discriminatory intent); *United States v. Yonkers Bd. of Educ.*, 837 F.2d 1181, 1216 (2d Cir. 1987) ("[T]o prove a claim of discrimination in violation of the Equal Protection Clause a plaintiff must show not only that the state action complained of had a disproportionate or discriminatory impact but also that the defendant acted with the intent to discriminate.").

117. Cf. *McCleskey v. Kemp*, 481 U.S. 279 (1987) (rejecting constitutional challenge to death penalty notwithstanding convincing statistical evidence of racial disparities in capital sentencing).

118. For a critique of the "false dichotomy" between disproportionate impact and intentional discrimination, see Charles R. Lawrence, III, *The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism*, 39 STAN. L. REV. 317, 321-23 (1987). Professor Lawrence argued that the required proof of discriminatory intent for an equal protection claim ignores the pervasiveness and the profound impact of unconscious discrimination, and he proposed a new test that would evaluate governmental conduct "to determine whether it conveys a symbolic message to which the culture attaches racial significance," in which case strict scrutiny would apply. See *id.* at 324. Professor Lawrence's test would not, however, apply strict scrutiny in those cases "where nonrace-dependent decisions . . . disproportionately burden blacks only because they are overrepresented or underrepresented among the decision's targets or beneficiaries." *Id.*

3. Other Statutory Remedies

Other statutes relating to the provision of health services also may provide avenues for addressing disparities in access to certain types of health care. When Congress initially enacted the Hill-Burton Act,¹¹⁹ it sought to provide federal funding for hospital construction. The Act provides a limited means of redress for patients against hospitals that implement discriminatory admissions policies. Under the Act, all facilities receiving these funds must provide “a reasonable volume of services to persons unable to pay” except if “such a requirement is not feasible from a financial viewpoint.”¹²⁰ The Act’s “community service obligation” also requires Hill-Burton facilities to furnish health care services in a non-discriminatory fashion.¹²¹ The original Act required participating hospitals to ensure that their facilities were available to all persons residing in the hospital’s territorial area without discrimination based on race, creed, or color, but this provision was later amended to require simply that facilities be available to all residing within the territorial area of the hospital receiving Hill-Burton funds.¹²²

The Act does not grant individual patients a private right of action to demand medical treatment, but it does permit individual suits to compel enforcement of the Act’s uncompensated care and community service provisions by the offending hospital.¹²³ Several cases interpreting the

119. Ch. 958, 60 Stat. 1041 (1946) (codified as amended at 42 U.S.C. § 291 (1994)).

120. See 42 U.S.C. § 291c(e)(2) (1994).

121. See, e.g., *Metro. Med. Ctr. v. Harris*, 693 F.2d 775, 787 (8th Cir. 1982) (noting that regulations implementing the Hill-Burton Act allow recipients of these federal funds to limit the availability of their services under the community service obligation only based on age, medical indigency, or type or kind of medical or mental disability, and that the statute and the regulations clearly suggest that Hill-Burton fund recipients refrain from “engaging in discriminatory admission practices”); *Lugo v. Simon*, 426 F. Supp. 28, 36 (N.D. Ohio 1976) (noting that a regulation placing a 20-year limit on the statute’s service requirement appears to be plainly inconsistent with the statutory language and is therefore impermissible).

122. See 42 U.S.C. § 291c(e)(i) (1990); see also *Simkins v. Moses H. Cone Mem’l Hosp.*, 323 F.2d 959 (4th Cir. 1963) (striking down an exception to the community service obligation that permitted “separate but equal” facilities); *Metro. Med. Ctr.*, 693 F.2d at 787. Implementing regulations elaborate on the anti-discrimination requirement. See 42 C.F.R. § 124.603(a), (d) (1996) (providing that Hill-Burton facilities may not discriminate based on “race, color, national origin, creed, or any other ground unrelated to an individual’s need for the service” and may not utilize admissions policies that have the effect of excluding persons on impermissible grounds).

123. See 42 U.S.C. § 300s-6 (1991); 42 C.F.R. § 124.606(a)(4); *Wey v. Evangelical Community Hosp.*, 833 F. Supp. 453, 461-62, 465 (M.D. Pa. 1993) (holding that a private individual may act as a “private attorney general” by bringing an action to ensure compliance with the provisions of the Hill-Burton Act, but finding no facts to support

Act have concluded, however, that individual private actions under the Act are limited to this enforcement role only and that the Act and its implementing regulations do not support suits for personal relief.¹²⁴ Thus, although an individual who is subjected to discriminatory admissions policies at a Hill-Burton hospital can file a private action to compel the hospital's compliance with statutory obligations, such a right of action appears more of a symbolic victory than a practical means of remedying the wrong.

Another statute provides limited remedies for victims of discriminatory or otherwise unequal access to emergency hospital care. The provisions of the Emergency Medical Treatment and Labor Act (EMTALA)¹²⁵ apply to all hospitals that receive federal Medicare funds and that have emergency departments or provide emergency medical care. Under the provisions of EMTALA, participating hospitals must screen every patient seeking emergency room services,¹²⁶ and, if the patient has an emergency medical condition,¹²⁷ they must stabilize the patient before

any violation in the case).

124. See *White v. Moses Taylor Hosp.*, 763 F. Supp. 776, 783 (M.D. Pa. 1991) (holding that an individual may bring a private action under the Hill-Burton Act to effectuate a funds-recipient's compliance with the Act but is restricted to enforcing the hospital's compliance with its "assurances" and may not seek personal relief); see also 42 U.S.C. § 300s-6 ("An action to effect compliance with any such assurances may be brought by a person other than the Secretary . . ."); 42 C.F.R. § 124.511(a)(4) ("[T]he person filing it may bring a private action to effectuate compliance with the assurance.").

125. Pub. L. No. 99-272, § 9121(b), 100 Stat. 164 (1986) (codified as amended at 42 U.S.C. § 1395dd (1994)). This Act is frequently referred to as "COBRA" because it was passed as part of this budget reconciliation act, or as the "Anti-Dumping Act" because it prohibits patient dumping.

126. See 42 U.S.C. § 1395dd(a) (1994) (requiring "an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . exists").

127. See *id.* § 1395dd(e)(1). This section defines an "emergency medical condition" as:

a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- (ii) serious impairment to bodily functions, or
- (iii) serious dysfunction of any bodily organ or part

Id. The next paragraph of the statute includes labor in the definition of an emergency medical condition requiring treatment. See *id.* § 1395dd(e)(1)(B).

transferring him or her.¹²⁸ Any individual who is harmed as a “direct result” of the hospital’s violation of the statute has a private right of action against the hospital.¹²⁹ Some courts have suggested that the hospital’s or the treating physician’s motive in transferring the patient may be relevant in proving that the hospital violated the Act, by failing either to provide an appropriate screening and stabilizing treatment or to properly determine that the benefits outweighed the risks of transfer.¹³⁰

In one recent case, the United States Court of Appeals for the Sixth Circuit found no evidence of a violation of EMTALA based on the facts of the case,¹³¹ but in dicta it included a detailed discussion about reasons other than indigency for denying appropriate care that might constitute a violation of the statute:

These might include: prejudice against the race, sex, or ethnic group of the patient; distaste for the patient’s condition (*e.g.*, AIDS patients); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient’s occupation; or political or cultural opposition. If a hospital refused treatment to persons for any of these reasons, or gave cursory treatment, the evil inflicted would be quite akin to that discussed by Congress in the legislative history, and the patient would fall squarely within the statutory language.¹³²

Thus, it appears that the Sixth Circuit would be willing to impose liability for disparate treatment under the “appropriate medical screening” provision of EMTALA as long as the plaintiff can prove a bad motive on the hospital’s part. In contrast, the United States Court of Appeals for the D.C. Circuit evidently would impose statutory liability for disparate treatment regardless of the hospital’s motives.¹³³ Finding no violation of the “appropriate medical screening” requirement, the court noted that “any departure from standard screening procedures

128. See *id.* § 1395dd(e)(3)(B) (providing that an individual is “stabilized” if “no material deterioration of the condition is likely, within reasonable medical probability” during or resulting from the individual’s transfer). The statute defines stabilization of a woman having labor contractions as delivery. See *id.*

129. See *id.* § 1395dd(d)(2)(A).

130. EMTALA permits transfer of non-stable patients in situations where the treating physician certifies that “the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual.” *Id.* § 1395dd(c)(1)(ii).

131. See *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266, 271 (6th Cir. 1990).

132. *Id.* at 272. The Fifth Circuit has cited *Cleland* with approval. See *Burditt v. HHS*, 934 F.2d 1362, 1370 n.8 (5th Cir. 1991) (“One may prove that a hospital has violated this standard by presenting evidence that something other than the present or projected medical needs of its patients determined the treatment provided.”).

133. See *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991).

would constitute an inappropriate screening in violation of [the Act].”¹³⁴

The remedies provisions of EMTALA are limited in scope. Plaintiffs suing under the “appropriate medical screening” theory can seek damages or equitable remedies from the hospital providing (or failing to provide) treatment.¹³⁵ The statute also establishes civil monetary penalties against the hospital and the “responsible” physician for violations of the Act.¹³⁶ Of course, remedies available under EMTALA only concern access to emergency medical care and leave many of the examples of disparate care described above unresolved.

B. Prospective Solutions

The following sections suggest several initiatives that, taken together, might begin to improve communication and to close the gap in utilization of health care treatments and services and, eventually, in the relative health statuses of white and minority patients. Education about the problem of racial disparities in health care delivery will likely be more effective than either litigation or regulation at changing the attitudes of institutional and particularly individual health care providers.¹³⁷ Because patient-specific treatment choices are the least amena-

134. *Id.* at 1041. The court acknowledged its departure from the reasoning in *Cleland* regarding the way “motives” relate to the issue, and added that “[t]he motive for such departure is not important to this analysis, which applies whenever and for whatever reason a patient is denied the same level of care provided others and guaranteed him or her by subsection 1395dd(a).” *Id.* at 1041, 1041 n.3.

135. See 42 U.S.C. § 1395dd(D)(2)(A) (1994) (permitting civil actions against hospitals for damages for personal injury and “such equitable relief as is appropriate”). Courts have, however, rejected suits against individual physicians and physician groups under the Act. See, e.g., *Delaney v. Cade*, 986 F.2d 387, 393-94 (10th Cir. 1993) (holding that the plain language of the statute indicates that individuals can bring civil suits only against hospitals, and not against individual physicians); *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 876-78 (4th Cir. 1992) (holding that the statutory language did not permit individuals to recover personal injury damages from a doctor based on violations of the Act).

136. See 42 U.S.C. § 1395dd(d)(1)(A), (B) (setting out penalties against hospitals of not more than \$50,000 (or not more than \$25,000 for hospitals with fewer than 100 beds) for each violation of the Act, and a penalty of not more than \$50,000 against individual physicians for each violation).

137. See *Miller & Curtis*, *supra* note 84, at 750-51 (discussing the potential negative consequences of race-specific health reform policies, such as stigmatization of the benefitting group, implying that such groups are homogenous and thus interfering with individualized patient care, and generally “fuel[ing] the flames of racial divisiveness,”

ble to scrutiny under statutory or constitutional standards, the following proposed approaches deserve serious consideration from the federal government and the medical community.

1. Medical Education

Evidence suggests that most patient complaints arise from communication problems with physicians.¹³⁸ In addition to affecting patients' perceptions about the care that they receive, communication significantly impacts patient adherence to prescribed medical regimens, such as medication and diet.¹³⁹ Because patient non-compliance with physician recommendations can contribute to undesirable therapeutic outcomes,¹⁴⁰ many medical schools are adding a communication skills component to their curriculum, either at the medical college or graduate medical education stage.¹⁴¹ Medical schools in the United States commonly offer a course or part of a course dealing with the physician-patient relationship. Most programs cover the subject as part of an existing required course, though others offer it as a stand-alone required or elective course.¹⁴²

and concluding that such mandates are ineffective at changing attitudes towards race issues).

138. See Tessa Richards, *Chasms in Communication: Physician-Patient Communication*, 301 BRIT. MED. J. 1407, 1407-08 (1990).

139. See Judith A. Hall et al., *Meta-Analysis of Correlates of Provider Behavior in Medical Encounters*, 26 MED. CARE 657, 666 (1988). Although the study did not focus on race, the study noted a trend suggesting that white patients receive more detailed information during consultation with providers than do African American patients. See *id.* at 667; see also Daniel E. Shapiro et al., *The Effect of Varied Physician Affect on Recall, Anxiety, and Perceptions in Women at Risk for Breast Cancer*, 11 HEALTH PSYCHOL. 61, 61-66 (1992).

140. See John Hornberger et al., *Bridging Language and Cultural Barriers Between Physicians and Patients*, 112 PUB. HEALTH REP. 410, 410-11, 416 (1997) ("When a physician and patient do not share a common language or culture, communication difficulties may compromise the patient's care, potentially resulting in worse health outcomes, especially among patients with complex or chronic medical problems.").

141. See Stephen R. Boggs et al., *Development and Evaluation of a Communications Skills Training Program for Resident Physicians* (1996) (unpublished manuscript, on file with author).

142. See ASSOCIATION AM. MED. COLLEGES, 1996-1997 CURRICULUM DIRECTORY 12 tbl.6 (indicating that 108 medical schools cover the physician-patient relationship as part of a required course, another 23 programs offer the course as a required separate course, and 23 offer the course as an elective); see also Mary Anne C. Johnston, *A Model Program to Address Insensitive Behaviors Towards Medical Students*, 67 ACAD. MED. 236, 236-37 (1992) (describing a program at the University of Pennsylvania School of Medicine designed to educate students and faculty members about insensitive behavior towards minority groups, women, and gays and lesbians, and noting that medical schools wishing to graduate sensitive and caring physicians can begin the process by addressing instances of disrespectful behavior that arise during the medical education program).

It is difficult to determine the content of such courses. In some medical schools, the "Introduction to Clinical Medicine" or equivalent course includes topics such as patient-interviewing and communication, as well as discussions about the interrelationship between race, gender, poverty, and health.¹⁴³ Along the same lines, Dr. Geiger, in his response to the HCFA study findings, urged medical schools to train students about issues surrounding race and health care, including the development of courses designed to increase sensitivity and improve understanding of diverse ethnic groups.¹⁴⁴ In addition, practicing physicians can educate their peers about these issues through continuing medical education programs.

As a corollary to such curricular responses, Congress must retain its commitment to encouraging the training of minority health care professionals.¹⁴⁵ Health care scholars and ethicists have argued that

143. See Elysa Gordon, Note, *Multiculturalism in Medical Decisionmaking: The Notion of Informed Waiver*, 23 *FORDHAM URB. L.J.* 1321, 1355 & n.193 (1996) (also describing other suggested approaches for improving cross-cultural communication in the healthcare context).

144. See Geiger, *supra* note 10, at 816. Dr. Geiger also suggested that physicians confront the following questions:

What choices are black patients and white patients actually offered by their physicians? What do they hear? Do their physicians make specific recommendations? Do the patients participate fully in the decision-making process? What criteria do physicians use in making these clinical judgments? Are they 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?

Id.; see also Gordon, *supra* note 143, at 1355 (suggesting practice guidelines and incentives that "encourage physicians to approach patients about their cultural values").

145. See Sullivan, *supra* note 2, at 2674. One set of programs, created under the Disadvantaged Minority Health Improvement Act of 1990, Pub. L. No. 101-527, 104 Stat. 2311 (codified in scattered sections of 42 U.S.C.), instituted a series of federally-funded grants and loan programs aimed at increasing the numbers of minority students enrolled in health professions schools. The Act provides grants to "centers of excellence" at medical and dental schools with the goals of establishing programs to enhance the academic performance of minority students, increasing the numbers of minority students in the programs, improving program recruiting and retention of minority faculty, and facilitating research on health issues affecting minority groups. See 42 U.S.C. §§ 2541, 295g-2 (1994). The Act also established grants for scholarships and loan repayment programs to support minority health professions students. See *id.* §§ 2541, 2541-1. The Health Resources and Services Administration recently announced that it will award \$13.5 million in funding awards for programs in medicine, dentistry, and pharmacy at historically black colleges, including Florida A&M University, Morehouse School of Medicine, and Texas Southern University. See *HRSA News* (visited Feb. 7, 1998) <<http://www.hrsa.dhhs.gov/News-PA/hbcumill.htm>>.

the minority patient population's lack of trust in the predominately-white medical system discourages these patients from seeking early medical attention, even when such care is accessible.¹⁴⁶ Encouraging minorities to enter the health care professions in greater numbers may help to create a culture of trust between the health care system and its minority patients.

2. *Professional Awareness and Institutional Responses*

In addition to the possibility of individualized prejudices,¹⁴⁷ unconscious racism may appear at an institutional level as well.¹⁴⁸ In this era of cost-consciousness, hospitals and insurers have created complex guidelines to limit the care that patients receive.¹⁴⁹ For example, an insurance plan that refuses reimbursement for an elective procedure if the patient previously has received less than optimal management of his or her disease may negatively impact minority patients, who tend to have less overall access to care. Although such guidelines certainly are not race-based, they may tend to perpetuate the prevalence of certain conditions among minority patients. As noted above, a variety of factors other than unconscious discrimination contribute to this problem: for whatever reason, African Americans tend to make fewer visits to physicians for ambulatory care than white patients, and they often present for initial care at later stages of disease than white patients. Low incomes appear to exacerbate these problems,¹⁵⁰ but the HCFA study

146. See Randall, *supra* note 75, at 191-92 (“[F]ear and distrust of the health care system is a natural and logical response to the history of experimentation and abuse. . . . That perspective keeps African Americans from getting health care treatment . . .”). Health policy specialists, physicians, and even corporations are beginning to respond to the problems created by this fear and distrust of the health care system. The Wrigley Corporation and Health Watch, a health advocacy group, recently joined together to produce an advertising campaign designed to encourage African Americans and other minorities to visit doctors for preventive care, and to seek early detection and control of disease. See *Wrigley Ads to Focus on Minority Health*, WALL ST. J., June 4, 1997, at B1.

147. Many people who have learned racist attitudes as children may decide to discard these attitudes as adults, but they may not succeed in keeping unconscious attitudes from affecting their decisionmaking. See Edward P. Boyle, Note, *It's Not Easy Bein' Green: The Psychology of Racism, Environmental Discrimination, and the Argument for Modernizing Equal Protection Analysis*, 46 VAND. L. REV. 937, 939 (1993).

148. See *id.* (“Institutional racism occurs when the group in power structures its social institutions so as to maintain its dominance over other groups.”).

149. See, e.g., Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219, 1225-29 (1997) (describing a variety of managed care cost-containment strategies).

150. See Gornick et al., *supra* note 7, at 793-94 (noting that in 1993 African American Medicare beneficiaries made 7.2 visits per person to physicians for ambulatory

demonstrated that differences in income alone do not account for the observed disparities in health care delivery. Institutional policies may reflect unconscious biases or, at the very least, a lack of concern about existing disparities.

Both physicians and health care institutions ultimately will bear the bulk of the responsibility for detecting and responding to patterns of disparate treatment. The forces of peer pressure, perhaps reinforced by the threat of regulatory action against the hospital,¹⁵¹ can provide a powerful incentive for individual and institutional self-monitoring. At the institutional level, hospitals might incorporate into their quality assurance protocols an ongoing evaluation and monitoring of racial disparities in the provision of services.¹⁵²

To this end, hospitals could create an anonymous reporting mechanism to help detect and respond to instances or patterns of discriminatory decisionmaking. In addition, periodic discussion among administrators, physicians, hospital ethics staff, and other relevant employees would serve to raise awareness of, and increase sensitivity to, racial and cultural issues. One commentator has proposed the creation of interdisciplinary care teams, comprised of social workers, nurses, psychiatrists, and patient advocates. The commentator observed that “[t]hese disciplines have historically considered the impact of individuals’ cultural identity in their theory and practice and patients may perceive these professionals as more closely aligned with their interests than physicians”¹⁵³ Another possible approach would incorporate racial and cultural considerations into the physician-patient dialogue by directly questioning patients about their treatment-related concerns, their views about medical decisionmaking, and relevant religious or ethical values.¹⁵⁴ Finally,

care compared with 8.1 visits per person among white patients).

151. See *supra* Part III.A.3.

152. See Geiger, *supra* note 10, at 816; see also AMA Council on Ethical & Judicial Affairs, *Black-White Disparities in Health Care*, 263 JAMA 2344, 2346 (1990) (proposing the development and use of practice parameters including criteria designed to diminish racial disparities).

153. See Gordon, *supra* note 143, at 1356 (footnote omitted).

154. See Robert D. Orr et al., *Cross-Cultural Considerations in Clinical Ethics Consultations*, 4 ARCHIVES FAM. MED. 159, 163 (1995). Orr and his co-authors also suggest that providers: (1) avoid making assumptions about the patient’s cultural or ethnic background; (2) consult with health care practitioners who share the same ethnic background as the patient; (3) avoid stereotyping patients based on their race or the language that they speak; (4) use non-family translators where possible; (5) be aware of

some HMOs and medical malpractice insurers now offer cultural sensitivity training to their physicians in an effort to improve communication and overall quality of care.¹⁵⁵

3. Regulatory Vigilance

Regulatory agencies also can play a role in focusing attention on the problem of racial inequalities in the health care system. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) might insist upon organizational self-monitoring and correction of unexplained disparities in the delivery of health services as a condition of continued accreditation for hospitals and other provider organizations.¹⁵⁶ In addition, HCFA might in the future require more careful utilization review methods designed to identify and correct any observed patterns of racial inequities in the delivery of services to Medicare and Medicaid recipients.

Similarly, UNOS, which already has demonstrated an awareness of these issues in organ allocation, will no doubt continue to gather information and shape its allocation policies in a manner that promotes sensitivity to race issues among the many players in the transplantation process. The UNOS Committee on Minority Affairs regularly monitors and evaluates the impact of race on access to transplantation at all

personal biases and prejudices; and (6) be sensitive to the provider's powerful influence over the patient and family during the decisionmaking process. *See id*; see also Ben A. Rich, *The Values History: A New Standard of Care*, 40 EMORY L.J. 1109, 1141-43, 1147-52 (1991) (advocating the use of a "values history"—an oral or written questioning of the patient—in order to (1) understand the patient's views about the type and degree of medical intervention that the patient would want should the patient's competency be compromised, and also to (2) facilitate the patient's autonomous decisionmaking by providing the physician and other caregivers with an understanding of the patient's wishes, fears, ethical values, and/or spiritual beliefs).

155. See George Anders, *Doctors Learn to Bridge Cultural Gaps*, WALL ST. J., Sept. 4, 1997, at B1 (describing how one large California HMO has a cultural anthropologist on staff to assist in the development of special health programs for minority members, and describing an independent organization that provides "cross-cultural workshops" for HMO clients and other healthcare providers).

156. Cf. Timothy Stoltzfus Jost, *Medicare and the Joint Commission on Accreditation of HealthCare Organizations: A Healthy Relationship?*, 57 LAW & CONTEMP. PROBS. 15, 38 (1994) ("The Joint Commission has often played a leading role in encouraging progressive change in the health care industry. Examples of recent reform-motivated additions to Joint Commission accreditation standards include requirements that hospitals institute policies to improve communication with non-English speaking patients . . ."). See generally Timothy Stoltzfus Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C. L. REV. 835 (1983) (describing JCAHO accreditation processes); James S. Roberts et al., *A History of the Joint Commission on Accreditation of Hospitals*, 258 JAMA 936 (1987).

stages, on registration at the transplantation center, on the allocation process, and on the ultimate success rates of each type of procedure.

In the areas of access to prescription drug therapy and diagnosis and treatment of mental illness, government agencies will find it more difficult to identify institutional policies or consistent patterns that could become targets for reform. To the extent that AIDS clinics receive federal funding and demonstrate a pattern of disparate prescribing of AIDS therapies, HCFA might respond with a requirement of more careful utilization monitoring to detect race-based inequities in care, and then require prompt responses to such inequities as a condition of continued funding. Addressing disparate prescribing patterns such as those in the pediatric prescription drug study described above may prove impossible at the governmental level. Such decisions are too much within the ambit of physician discretion, and probably rightly so, to be captured and reformed by a regulatory initiative. Even so, the government may decide to encourage additional study of these issues, perhaps by providing grants for appropriately designed research.

By carefully monitoring compliance with its 1990 directive, NIH can reduce or eliminate underrepresentation of minorities and women in clinical trials. Clinical investigators and pharmaceutical manufacturers also can play a greater role in combating this problem. One commentator has proposed several ways of improving scientific understanding of the varying drug responses among patients of different racial and ethnic backgrounds.¹⁵⁷ Clinical investigators, and also the journal editors who publish the results of these trials, should include data on the racial composition of the study group whenever possible. In addition, pharmaceutical manufacturers, in the course of developing new drugs, should attempt to increase the enrollment of African Americans and other minorities in clinical trials, particularly when the drugs in question are intended to treat conditions that affect a disproportionately large percentage of minority patients.¹⁵⁸

4. *Other Governmental Initiatives*

The federal government can reaffirm its commitment to ending disparate health care treatment for minorities in the United States in

157. See Svensson, *supra* note 68, at 265.

158. See *id.*

other ways. In 1994, President Clinton issued an Executive Order regarding federal action to promote environmental justice for minority and low-income populations.¹⁵⁹ The Order created an interagency working group on environmental justice designed to provide guidance to federal agencies “for identifying disproportionately high and adverse human health or environmental effects on minority populations. . . .”¹⁶⁰ The Order charged the group with developing environmental justice strategies, coordinating research, and collecting data to address the disparate effects of federal environmental policy on minorities.¹⁶¹ A similar Executive Order creating an interagency working group to address racial issues in the provision of health care could provide the coordination of governmental agency activity needed to respond to existing disparities on a broad scale.

Such a working group could perform several useful functions. First, it could monitor and track existing disparities by compiling and analyzing data from a variety of sources. HCFA obviously would be asked to provide data on utilization rates for Medicare and Medicaid services (as in the study discussed above, but on a broader and more regular basis). Other agencies, such as NIH, CDC, UNOS, and the FDA also might supply relevant data.¹⁶² Second, the working group could use this data to develop strategies for both agencies and provider institutions to address any identified racial disparities.¹⁶³ The working

159. See Exec. Order No. 12,898, 59 Fed. Reg. 7629 (1994). Interesting parallels exist between health care discrimination and recent scholarship suggesting constitutional approaches to what has been characterized as “environmental racism.” For example, recent articles have suggested that “environmental racism” impacts decisions such as the siting of toxic dumps and cleanup efforts, but the articles nevertheless conclude that equal protection analysis is unlikely to assist those seeking to claim unlawful discrimination in these contexts. See, e.g., Naikang Tsao, *Ameliorating Environmental Racism: A Citizen’s Guide to Combatting The Discriminatory Siting of Toxic Waste Dumps*, 67 N.Y.U. L. REV. 366, 406-07 (1992); Boyle, *supra* note 147, at 979-80; cf. Lynn E. Blais, *Environmental Racism Reconsidered*, 75 N.C. L. REV. 75, 132, 142 (1996) (noting that most environmental equity activists do not allege that siting decisions are made based on invidious criteria but rather result from the disproportionate impact of facially neutral policies, and suggesting that existing disproportionate impacts result from inequalities of wealth).

160. Exec. Order No. 12,898, § 1-102(b), 59 Fed. Reg. at 7629.

161. See *id.*

162. The working group should provide minority populations with the opportunity to comment on the development of research strategies designed to analyze the issue of how race affects the provision of health care.

163. Such an Executive Order might mandate that each federal agency responsible for health related issues conduct all activities that affect human health “in a manner that ensures that such programs, policies, and activities do not have the effect of excluding persons (including populations) from participation in, denying persons (including populations) the benefits of, or subjecting persons (including populations) to discrimination under such programs, policies, and activities because of their race, color, or national

group would seek to accomplish several goals including provider education and sensitization to issues of race in health care, as well as improving outreach and education for minority communities to increase the utilization of preventive care and early detection of disease. Although race is difficult to isolate from factors like insurance status and income that also affect the provision of health care, the working group's direct confrontation of the role that race plays would represent an important step toward improving health care for those whose access to care currently is inadequate.

IV. CONCLUSION

Socioeconomic factors explain only a portion of the racial disparities that exist in health care delivery. Recognition of these disparities, whatever their source, demands a swift response. The medical and legal communities must begin to address race-based variations in treatment, such as differences in the rates at which certain medical procedures are performed, allocation policies that create racial disparities in the rates of organ transplantation, access to prescription drug therapy, the diagnosis and treatment of mental illness, and the failure to include historically underrepresented groups in clinical research.

Existing legal remedies will provide little recourse to the victims of these disparities. Until changes in the relevant statutory and constitutional standards permit a judicial response, the medical community and governmental agencies must confront the problem at its source, by educating and regulating health care providers as well as others who control the medical decisionmaking process. Mechanisms already exist to identify and reduce racial disparities in the delivery of health care services, but there has not been a full appreciation of the extent of this problem. More research—controlling for critical variables such as race, income levels, insurance coverage, severity of disease, and pre-existing health conditions—will help to clarify the nature and extent of these disparities, and the role that conscious or unconscious racial bias may play in perpetuating them. Meanwhile, it is important to implement a variety of approaches to deal with the existing racial inequalities, whatever their source. At the same time, members of the medical community and state and federal governments should carefully examine

origin." Exec. Order No. 12,898, § 2-2, 59 Fed. Reg. at 7630.

their motivations in making treatment decisions and in designing health policy. Although perfect equity in the provision of health services does not guarantee equality of health status among the races, it constitutes an important step towards better health for all Americans.