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Foreword

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FOREWORD

SIDNEY D. WATSON*

Each year the *Saint Louis University Law Journal* and the School of Law's Center for Health Law Studies host a Symposium on health law. This past year marked the fifteenth Annual Health Law Symposium, and the topic was *Unequal Treatment: Racial and Ethnic Disparities in Health Care*. The Symposium explored the causes of racial and ethnic disparities in health status and treatment, the history and legacy of racial segregation in health care, and the role that law can play in redressing and reducing these disparities.

For the first thirty years after Title VI of the Civil Rights Act of 1964 outlawed racial discrimination by federally funded health care providers, only a handful of law review articles struggled to articulate the causes for and the remedies to redress racial disparities in health care access and treatment.¹

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1. See, e.g., Michael Meltsner, *Equality and Health*, 115 U. PA. L. REV. 22 (1967); Kenneth Wing, *Title VI and Health Facilities: Forms Without Substance*, 30 HASTINGS L.J. 137 (1978); Richard J. Zall, Note, *Maintaining Health Care in the Inner City: Title VI and Hospital Relocations*, 55 N.Y.U. L. REV. Note, 271 (1980); Mitchell A. Horwich, Comment, *Title VI of the 1964 Civil Rights Act and the Closing of a Public Hospital*, 1981 DUKE L.J. 1033 (1981); Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn't Be So Easy*, 58 FORDHAM L. REV. 939 (1990); Gordon Bonnyman, Jr., *Unmasking Jim Crow*, 18 J. HEALTH POL., POL'Y & L. 871 (1993); Vernellia R. Randall, *Racist Health Care: Reforming an Unjust Health Care System to Meet the Needs of African-Americans*, 3 HEALTH MATRIX 127 (1993); Sidney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C. L. REV. 1647 (1993); Marianne L. Engelman Lado, *Breaking the Barriers of Access to Health Care: A Discussion of the Role of Civil Rights Litigation and the Relationship Between Burdens of Proof and the Experience of Denial*, 60 BROOK. L. REV. 239 (1994); Sylvia A. Law, *A Right to Health Care That Cannot Be Taken Away: The Lessons of Twenty-Five Years of Health Care Advocacy*, 61 TENN. L. REV. 771 (1994); Sidney Dean Watson, *Minority Access to Health Reform: A Civil Right to Health Care*, 22 J. L., MED. & ETHICS 127 (1994); Daniel K. Hampton, Note, *Title VI Challenges by Private Parties to the Location of Health Care Facilities: Toward A Just and Effective Action*, 37 B.C. L. REV. 517 (1996); 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 (1996).

Much of the literature about health care discrimination during this time was written by and for practicing attorneys and appeared in *Clearinghouse Review*, a periodical for legal services attorneys. See, e.g., Stan Dorn et al., *Anti-Discrimination Provisions and Health Care Access: New Slants on Old Approaches*, 20 CLEARINGHOUSE REV. 439 (1986); Geraldine Dallek, *Health Care for America's Poor: Separate and Unequal*, 20 CLEARINGHOUSE REV. 361 (1986);

Since 1996, however, legal scholarship concerning racial and ethnic disparities in medical care has exploded,² fueled by a growing body of empirical research

Cassandra Q. Butts, *The Color of Money: Barriers to Access to Private Health Care Facilities for African-Americans*, 26 CLEARINGHOUSE REV. 159 (1992); Jane Perkins, *Race Discrimination in America's Health Care System*, 27 CLEARINGHOUSE REV. 371 (1993).

2. See, e.g., Barbara A. Noah, *Racist Health Care?*, 48 FLA. L. REV. 357 (1996); Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191 (1996); 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 (1997); Sidney D. Watson, *Race, Ethnicity & Hospital Care: The Need for Racial and Ethnic Data*, 30 J. HEALTH & HOSP. L. 125 (1997); Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135 (1998); Patricia A. King & Leslie E. Wolf, *Empowering and Protecting Patients: Lessons for Physician-Assisted Suicide from the African-American Experience*, 82 MINN. L. REV. 1015 (1998); Larry J. Pittman, *Physician-Assisted Suicide in the Dark Ward: The Intersection of the Thirteenth Amendment and Health Care Treatments Having Disproportionate Impacts on Disfavored Groups*, 28 SETON HALL L. REV. 776 (1998); David Barton Smith, *Addressing Racial Inequities in Health Care: Civil Rights Monitoring and Report Cards*, 23 J. HEALTH POL., POL'Y & L. 75 (1998); Steven P. Wallace et al., *The Consequences of Color-Blind Health Policy For Older Racial and Ethnic Minorities*, 9 STAN. L. & POL'Y REV. 329 (1998); Frank M. McClellan, *Is Managed Care Good for What Ails You? Ruminations on Race, Age and Class*, 44 VILL. L. REV. 227 (1999); Heather K. Aeschleman, Note, *The White World of Nursing Homes: The Myriad Barriers to Access Facing Today's Elderly Minorities*, 8 ELDER L.J. 367 (2000); Sara Rosenbaum et al., *U.S. Civil Rights Policy and Access to Health Care by Minority Americans: Implications for a Changing Health Care System*, 57 MED. CARE RESEARCH & REV. 236 (Supp. No. 1, 2000); M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL'Y, L. & ETHICS 95 (2001); René Bowser, *Racial Bias in Medical Treatment*, 105 DICK. L. REV. 365 (2001); René Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79 (2001); Cara A. Fauci, Note, *Racism and Health Care in America: Legal Response to Racial Disparities in the Allocation of Kidneys*, 21 B.C. THIRD WORLD L.J. 35 (2001); Michele Goodwin, *Deconstructing Legislative Consent Law: Organ Taking, Racial Profiling & Distributive Justice*, 6 VA. J.L. & TECH. 2 (2001); Dean M. Hashimoto, *The Proposed Patients' Bill of Rights: The Case of the Missing Equal Protection Clause*, 1 YALE J. HEALTH POL'Y, L. & ETHICS 77 (2001); Marianne Engelman Lado, *Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery*, 6 TEX. F. ON C.L. & C.R. 1 (2001); Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 AM. J. L. & MED. 203 (2001); Barbara Noah, *The Invisible Patient*, 2002 ILL. L. REV. 121 (2002) (reviewing SALLY SATEL, HOW POLITICAL CORRECTNESS IS CORRUPTING MEDICINE (2000)); Vernellia R. Randall, *Racial Discrimination in Health Care in the United States as a Violation of the International Convention on the Elimination of All Forms of Racial Discrimination*, 14 U. FLA. J.L. & PUB. POL'Y 45 (2002); Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 YALE J. HEALTH POL'Y, L. & ETHICS 215 (2003); Michael S. Shin, Comment, *Redressing Wounds: Finding a Legal Framework to Remedy Racial Disparities in Medical Care*, 90 CAL. L. REV. 2047 (2002); Anna I. Balsa et al., *Clinical Uncertainty and Healthcare Disparities*, 29 AM. J. L. & MED. 203 (2003); Mary Ann Bobinski, *Health Disparities and the Law: Wrongs in Search of A Right*, 29 AM. J. L. & MED. 363 (2003); Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 VILL. L. REV. 195 (2003); Gwendolyn Roberts Majette, *Access to Health*

exploring the nature and extent of racial disparities in health care. This Symposium recognizes this symbiotic relationship between law and empiricism, and it has brought the two together for this discussion.

Before 1996, empirical data on racial disparities in health care were also sparse. Narrative accounts of discrimination and differential treatment abounded and studies repeatedly documented that minority Americans used fewer physician and hospital services than white Americans, but little else was known about the extent of the racial disparities in health care access and quality of treatment. Commentators assumed that racial and ethnic disparities were interwoven with the financial and non-financial barriers associated with living in poverty, including lack of private insurance, transportation and child care, and geographic isolation from health care facilities and professionals. However, almost no empirical data attempted to unravel and examine the role that race and ethnicity played as independent variables. Without this empirical data, legal scholars could only speculate about the appropriate scope of legal remedies, particularly the role of civil rights laws like Title VI, which outlaws intentional and disparate-impact discrimination based upon race or ethnicity but does not directly address economic discrimination. So the question remained unanswered: Were racial and ethnic disparities in health merely a byproduct of economics and class, or was race itself a determining factor in the care one received?

The primary reason for the historical dearth of empirical data on racial and ethnic disparities in health care is that researchers did not have access to health services data that included information about patient race and ethnicity. Health care providers are not required to routinely collect and report data about the race and ethnicity of their patients. The United States Department of Health and Human Services (HHS) has the authority under Title VI of the Civil Rights Act of 1964 to require states and providers who receive Medicaid and Medicare to collect and report data on the race and ethnicity of their patients,

Care: What A Difference Shades of Color Make, 12 ANNALS HEALTH L. 121 (2003); Barbara A. Noah, *The Participation of Underrepresented Minorities in Clinical Research*, 29 AM. J. L. & MED. 221 (2003); Steven P. Wallace & Valentine M. Villa, *Equitable Health Systems: Cultural and Structural Issues for Latino Elders*, 29 AM. J. L. & MED. 247 (2003); Thomas E. Perez, *The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status*, in COMMITTEE ON UNDERSTANDING AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 626 (Brian D. Smedley et al. eds., 2003) [hereinafter UNEQUAL TREATMENT]; Sara Rosenbaum, *Racial and Ethnic Disparities in Healthcare: Issues in the Design, Structure and Administration of Federal Healthcare Financing Programs Supported Through Direct Public Funding*, in UNEQUAL TREATMENT, *supra*, at 664; Laine Friedman Ross & Catherine Walsh, *Minority Children in Pediatric Research*, 29 AM. J. L. & MED. 319 (2003); Joel Teitelbaum & Sara Rosenbaum, *Medical Care as a Public Accommodation: Moving the Discussion to Race*, 29 AM. J. L. & MED. 381 (2003); Louise G. Trubek & Maya Das, *Achieving Equality: Healthcare Governance in Transition*, 29 AM. J. L. & MED. 395 (2003).

but the department has declined to impose a regular reporting requirement on federally-funded health care providers.³

In 1994, prompted by a lawsuit⁴ and other advocacy efforts, HHS improved its system for computer cross-matching of race and ethnicity data recorded in Social Security enrollment records with Medicare billing and claims forms.⁵ HHS also began making this data available to health services researchers. In 1996, HHS published its first broad-based research study using this data to examine medical services provided to 26.3 million white and Black Medicare beneficiaries age 65 or older.⁶ The study, by Marian E. Gornick and colleagues, found evidence of widespread race-based treatment disparities—disparities that could not be explained by either source of insurance or income.⁷ The empirical question that legal scholars had asked was being answered. Race, as well as income, does account for the dramatic disparities in medical care between white and minority Americans.

The Gornick study and HHS's decision to make its Medicare records available to researchers prompted a flood of empirical research exploring racial and ethnic disparities in care. Between 1996 and 2002, more than one hundred such studies were reported in the medical literature.⁸ Some studies used Medicare claims data, others retrospectively reviewed patient records, and still others followed patients during their care. All of the studies controlled for factors other than race that might account for differences in care. The studies overwhelmingly conclude that racial and ethnic minorities receive different—and less—treatment than do white Americans.

The study that attracted the most media attention and the notice of lawmakers, however, is the 1999 study by Kevin A. Schulman and colleagues published in the *New England Journal of Medicine* entitled *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*.⁹ The researchers studied 720 primary care physicians who each viewed a videotaped patient interview to determine whether the patient should be referred for cardiac catheterization. The eight patient-actors who appeared in the videos used the same script, had the same clinical symptoms, history, source of insurance and income, wore the same clothes, and even bore a dramatic physical resemblance to each other. The research model controlled tightly for

3. See *Madison-Hughes v. Shalala*, 80 F.3d 1121 (6th Cir. 1996).

4. See *id.*

5. See Bruce C. Vladeck, *From the Health Care Financing Administration: Race and Ethnicity Data Collections*, 272 JAMA 761 (1994).

6. 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).

7. See *id.*

8. See, e.g., UNEQUAL TREATMENT, *supra* note 2, at 39 and Appendix B.

9. Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618 (1999).

every variable except race and sex. Among the eight actors were four whites, four African-Americans, four women and four men. The Schulman study found a statistically significant difference in referral rates based upon the race and gender of the patients—the patient’s race and gender affected the likelihood of primary care physicians referring the patient for cardiac catheterization.¹⁰ The Schulman study, which also published the photos of its actor–patients in the *New England Journal of Medicine*, put a face and a touch of humanity on the statistical studies. It provided vivid, graphic evidence that racial and ethnic disparities in care are about race and ethnicity and not primarily attributable to socioeconomic status and the patient’s source of insurance.

Soon after publication of the Schulman study, and prompted by concern generated by that study and other empirical work, Congress passed the Health Care Fairness Act of 2000.¹¹ Among other things, the Act directed the National Academy of Sciences to conduct a comprehensive study to assess the extent to which racial and ethnic disparities in health care are race-based rather than economic, to identify the causes of these disparities and to recommend interventions to alleviate racial and ethnic disparities in health care.¹² In 2002, The Institute of Medicine issued the report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. The report reviews the hundreds of research studies now available and concludes that there are remarkably consistent racial and ethnic disparities across a range of illnesses and health care services that cannot be attributed to economic status or access to care.¹³ The report also concludes that institutional and individual racial bias and racial discrimination—albeit primarily of the unconscious and subconscious variety—contribute to these disparities.¹⁴

Thus, in the realm of racial and ethnic disparities in health care, law and legal advocacy helped jumpstart the empirical research. The empirical research is now informing a robust legal scholarship. This Symposium has brought together the empirical scholarship with legal and policy analysis to examine the nature and extent of health and health care disparities as well as the nature of discrimination in health care.

Saint Louis University’s Health Law Symposium adds to the law journal literature articles by two of the foremost empirical scholars on racial and ethnic disparities in health care, Dr. David R. Williams and Dr. David Barton Smith. Dr. Williams is Professor of Sociology and Research Scientist at the Institute for Social Research at the University of Michigan. Dr. Williams’ research

10. *Id.*

11. Health Care Fairness Act of 2000, H.R. 3250, 106th Cong. (2d Sess. 2000)

12. *Id.* at § 301(b).

13. UNEQUAL TREATMENT, *supra* note 2, at 5.

14. *Id.* at 9-12.

focuses on the social and psychological factors that affect health, with special attention to how socioeconomic status and the experience of racial discrimination and racism affect health. Dr. Williams is a member of the Institute of Medicine (IOM) and served on the IOM Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, which authored the 2002 report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.

Dr. David Barton Smith delivered the Symposium's Keynote Address, focusing on the turbulent history of race within our nation's health care system. He is a Professor in the Healthcare Management Program of the Fox School of Business and Management at Temple University. Dr. Smith is one of the first health services researchers to publish empirical data on the extent of segregation in America's health care delivery system. In 1994, Dr. Smith received a Robert Wood Johnson Health Policy Research Investigator Award for research on the history and legacy of racial segregation of health care. His recent book, *Health Care Divided: Race and Healing a Nation*,¹⁵ is the definitive history of the civil rights struggle in the context of the health care system.

While it is unusual for a law journal to publish works by non-lawyers, it is the facts—historical, empirical and sociological—that ought to guide law and policy. The growing cadre of health law scholars writing about racial and ethnic disparities in health and health care depend heavily on the work of Drs. Smith and Williams and others like them. This issue of the *Saint Louis University Law Journal* endeavors to make their empirical work more accessible to a wider readership among those who think, write, and practice law, and their scholarship marks the point of departure for our legal analysis.

Dr. David Williams' article in this issue, *Race, Health and Health Care*, provides an overview of the large and persistent racial and ethnic disparities in health status and health care in the United States. Dr. Williams examines health disparities both for racial and ethnic minorities with a long-term history of geographic and socioeconomic isolation and discrimination—African-Americans and American Indians—and for those who are more recent immigrants to the United States—Asian-Americans and Hispanics. The article describes the complex ways in which race, ethnicity and socioeconomic status combine to affect health status, debunking any misconception that racial and ethnic health disparities are biological rather than cultural. This myth of biological difference persists because the literature reports that racial and ethnic disparities in health are reduced but not erased when one compares white Americans and African-Americans of similar socioeconomic class. However, as Dr. Williams points out, researchers typically use education as the indicator for socioeconomic class, a marker that does not reflect economic

15. DAVID BARTON SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION* (2003).

differences attributable to our country's long history of segregation. For example, similarly educated African-Americans earn less than their white counterparts, have substantially less accumulated wealth from homeownership, and tend to live in segregated neighborhoods that are socially and physically more risky. Moreover, a growing body of scientific literature suggests that the experience of discrimination and the stress it causes adversely affects the health of minority Americans.

Dr. Williams also looks at the growing body of recent literature on racial and ethnic disparities in health care access and quality. While multiple factors contribute to the racial and ethnic disparities in care—geographic maldistribution of health resources in mostly white neighborhoods, institutional policies of private hospitals and health systems, and patients' trust, knowledge and prior experiences with the health care system—discrimination by health care professionals plays an important, albeit unconscious and unintentional, role. As Dr. Williams' statistics graphically show, white Americans, as a group, hold negative perceptions about Africans, Hispanics and Asians. Not only do white health care professionals bring these misconceptions to their work, medical care is rendered under the kind of constraints—time pressure, brief encounters, and the need to manage complex, cognitive tasks—that are likely to enhance reliance on negative stereotyping because there is simply not enough time available to get to know each patient.

In *Healthcare's Hidden Civil Rights Legacy*, Dr. Smith tells the distressing story of health care civil rights. For more than half a century, Jim Crow laws segregated hospital care and physician practices. In some communities, white hospitals and white physicians refused to care for Black patients. In others, racially segregated hospitals clustered together to accommodate white physicians with racially mixed practices. Throughout the country, Black physicians and nurses, banned from white hospitals, survived—and became politically independent of the white power structure and white politicians—by developing a separate system of health care with its own Black hospitals to serve the Black communities.

A sequence of interlocking events occurred between 1948 and 1968 that led to the quick and quiet desegregation of America's hospitals: the organization of Black physicians and dentists, a federal court order, passage of Title VI of the Civil Rights Act of 1964, and the implementation of Medicare. While the integration of American hospitals was a profound change, shifts in the organization of medical care diluted its impact. Hospitals offered more private hospital rooms and reduced lengths of stay. A separate, racially segregated nursing home industry emerged. Ambulatory care became more important while racial segregation in physician practices remained untouched, as white physicians continued to treat primarily white patients while minority physicians treated minority patients. As Dr. Smith explains, this is the hidden civil rights story that offers the historical explanation for today's persistent

racial and ethnic disparities in nursing home care, physician practices, and specialized and diagnostic services.

After this grounding in the sociological and historical literature, the Symposium articles address the role of law in reducing racial and ethnic disparities in health and health care. The first of these articles is by Gordon Bonnyman, the co-founder and Executive Director of the Tennessee Justice Center. A practicing lawyer and passionate advocate, Mr. Bonnyman is an expert on Title VI of the Civil Rights Act of 1964 in the health law context. Mr. Bonnyman represented the plaintiffs in two precedent-setting Title VI health care cases, *Madison-Hughes v. Shalala*¹⁶ and *Linton v. Tennessee Commissioner of Health and Environment*.¹⁷

In *Dynamic Conservatism and the Demise of Title VI*, Mr. Bonnyman examines the history of Title VI as a tool for enforcing racial equality in health care. The article examines the influence that federal funding policy can have on minority health care. It demonstrates how the federal government has used—and failed to use—federal funding policy as a tool to improve minority health. The article concludes with an exploration of the ways that legislative and executive branch policies have undermined Title VI in the health care context. The government’s most spectacular lapse, according to Bonnyman, is the failure of HHS to require federally funded health care providers to collect and report data about the race and ethnicity of the patients they serve. While the research studies of racial and ethnic disparities in care are important, without institution-specific data, the federal government cannot monitor Title VI compliance on a regular basis and is severely hampered when it tries to investigate complaints of discrimination.

At the live Symposium, Professor Thomas Pérez, the Director of the Clinical Law Program at University of Maryland School of Law, spoke about the civil rights dimension of cultural competency. Professor Pérez was the Director of the Office for Civil Rights in the U.S. Department of Health and Human Services during the Clinton Administration. During his tenure, HHS issued the first proposed Title VI guidance since the Carter Administration. This guidance addressed access to health care for people with limited English language proficiency and offered a template for conceiving cultural competency standards within the framework of Title VI’s anti-discrimination mandate.

Lisa Ikemoto is a Professor of Law at Loyola Law School—Los Angeles and a leading feminist and critical health law scholar. Her article, *Racial Disparities in Health Care and Cultural Competency*, is a commentary on Professor Pérez’s talk, and it argues for legally mandated cultural competency

16. *Madison-Hughes v. Shalala*, 80 F.3d 1121 (6th Cir. 1996).

17. *Linton v. Tenn. Comm’r of Health & Environ., State of Tenn.*, 65 F.3d 508 (6th Cir. 1995), *cert. denied*, 517 U.S. 1155 (1996).

requirements for health care. The present debate about proposals to mandate cultural competency for health care providers focuses narrowly on the financial costs and benefits of limited initiatives to require translation services for patients with limited English language proficiency. This circumscribed debate assumes the benefits of free market individualism and physician autonomy while ignoring the pervasive, though often unintentional, racism that infects health care delivery at both the institutional and individual provider levels.

Professor Ikemoto draws on social science literature to rebut the myth that the practice of medicine and the health care system are race-neutral endeavors. She shows how hierarchical authority within the health care industry combines with individual discretion in diagnosing and treating patients to create space within which racist behavior operates as unconscious bias, stereotyping, racial profiling, and medical standards that are based on essentializing white behavior while pathologizing the behavior of minority group members.

From this broadened perspective on the role of unconscious racism, Professor Ikemoto argues for a more ambitious vision of the role of law in the health care context to reduce racial and ethnic disparities in health and health care. Professor Ikemoto calls for an expanded role for law in mandating a broader version of cultural competency that seeks to address both institutional and individual racism. This more ambitious legal agenda aims at organization-wide transformation through increased staff diversity and affirmative action mandates. It would require cross-cultural training programs to help medical care providers understand their own attitudes about race and ethnicity and to appreciate how the health care delivery system impacts minority health and health care. It would also protect patients by promoting patient equality through enhanced informed consent requirements to supplement existing anti-discrimination provisions of Title VI of the Civil Rights Act of 1964.

Professor Larry Pittman, Associate Professor of Law and Jessie D. Pucket, Jr., Lecturer at the University of Mississippi School of Law, is a health law scholar whose writing focuses on racial and ethnic disparities in medical care and treatment. In *A Thirteenth Amendment Challenge to Both Racial Disparities in Medical Treatments and Improper Physicians' Informed Consent Disclosures*, Professor Pittman focuses on racial and ethnic disparities in physician treatment decisions, particularly disparities in the treatment of African-Americans as compared to white Americans. Professor Pittman provides the reader with an encyclopedic survey of the research confirming widespread race-based discrepancies in clinical care for African-Americans. A stunning historical review of the mistreatment of African-American patients by the white medical establishment from the time of slavery through Reconstruction and into the middle of the Twentieth Century shows how the myth of "Black inferiority" was passed down from generation to generation, infecting treatment decisions by today's medical professionals. Drawing on the work of Professor Charles R. Lawrence and others, Professor Pittman

explains how the myth of Black inferiority translates into powerful negative feelings about African-Americans. While neither recognized, acknowledged nor conscious, these negative feelings manifest themselves at an irrational, subconscious level as unconscious racism and offer a powerful explanation for the race-based treatment disparities between African-Americans and white Americans.

Because race-based disparities in clinical decisions are grounded in the myth of Black inferiority that justified and supported slavery, Professor Pittman proposes that the Thirteenth Amendment should outlaw this unconscious discrimination as a “badge and incident” of slavery. Professor Pittman outlines the burden of proof and the available defenses to such a claim. He concludes by showing how the Thirteenth Amendment also requires that informed consent doctrine be altered to mandate that physicians, as part of their informed consent disclosure, tell African-Americans patients of the race-based disparities between the treatments that physicians have historically recommended for them compared to those recommended for white Americans.

This Symposium concludes on an historical and local note with a piece by Daniel Berg, M.D., entitled *A History of Health Care for the Indigent in St. Louis: 1900–2001*. Dr. Berg, a lifelong resident of St. Louis, just completed his residency training at Washington University. He is presently working with the Public Health Service at Gallup Indian Medical Center in Gallup, New Mexico. The City of St. Louis was the site of one of the nation’s premier African-American hospitals, Homer G. Phillips Hospital. From 1937 to 1979, Homer G. Phillips Hospital was a leading training center for African-American physicians and nurses. Staffed and administered by African-Americans, Homer G. Phillips Hospital was an organization both of and for St. Louis’ African-American community. It was a source of community pride. Dr. Berg’s piece recounts the history of racial discrimination in St. Louis that brought about Homer G. Phillips Hospital and explains how integration and white flight eventually caused the hospital’s closing.

Dr. Berg’s article is also a history of public health care in St. Louis. It tells of the rise and fall of four public hospitals, ending with the demise of all public hospitals in the region. Dr. Berg ends by describing the City’s present system of health care for the poor, which is characterized by fragmentation, funding uncertainties, and a racial polarization that dates from the last days of Homer G. Phillips Hospital. Dr. Berg explains how and why the health care system in St. Louis got where it is today.

During the Symposium, a distinguished Roundtable Panel added an epilogue to Dr. Berg’s article. The panelists described the present dramatic racial and ethnic disparities in health quality and health care in the St. Louis metropolitan region, and they outlined the massive planning effort that the community has undertaken under the auspices of the St. Louis Regional Health Commission to begin addressing and reducing disparities while building a

sustainable system of care for those who are poor or uninsured. The knowledgeable Roundtable speakers included: James R. Kimmey, M.D., M.P.H., President of the Missouri Foundation for Health; Richard Kurz, Ph.D., a professor at the Saint Louis University School of Public Health; Robert Freund, Jr., Chief Executive Officer of the St. Louis Regional Health Commission; Louise Quesada, M.P.H., of the City of St. Louis Department of Health; Ronnie Drake, DDS, a dentist in private practice in St. Louis; Roxanne Parker, of Patient Navigator with the Siteman Cancer Center Witness Project, and Edina Karahodzic, M.D., a resident at Forest Park Hospital who will soon be entering private practice in St. Louis. The statistics detailing racial and ethnic disparities in health quality and health care in the St. Louis region and the barriers that face patients seeking access to health care are documented in the St. Louis Regional Health Commission's Report entitled *Building a Healthier Saint Louis*.¹⁸

On behalf of the Center for Health Law Studies at the Saint Louis University School of Law, I want to thank all of the authors who wrote for this issue and those who spoke at the Symposium. Their thoughtful examination of the issues of racial and ethnic disparities in health care make an important contribution to this ongoing discussion. Thanks, as always, to Mary Ann Jauer, the Program Coordinator of the Center for Health Law Studies, whose dedicated work made the day-long symposium such a great success. A special thanks to Brian Nolan, the Managing Editor of this issue, and to the other *Saint Louis University Law Journal* students who branched out into sociology, history, medicine, and health sciences in search of sources, facts and public policy.

18. SAINT LOUIS REGIONAL HEALTH COMMISSION, BUILDING A HEALTHIER SAINT LOUIS: A REPORT ON THE INTEGRITY OF SAINT LOUIS' HEALTH CARE SAFETY NET (2003), available at <http://www.stlrhc.org/Recommendations.aspx>.

