The Bridge: Interdisciplinary Perspectives on Legal & Social Policy

Volume 6
Issue 3 *Systemic Racism and Minority Disparities in Health Care*

Article 1

2021

Systemic Racism and Minority Disparities in Health Care

Constance Fain
Thurgood Marshall School of Law, constance.fain@tmslaw.tsu.edu

SYSTEMIC RACISM AND MINORITY DISPARITIES IN HEALTH CARE

Constance Frisby Fain*

*Professor of Law, Thurgood Marshall of School Law; LL.M., University of Pennsylvania; J.D., Texas Southern University; B.S., Cheyney University of Pennsylvania. The author thanks the following persons for their valuable research assistance and technical support: Dr. Kimberly K. Fain; Attorney Melissa Rickard; and Dr. Herbert Fain.

I. INTRODUCTION

Racial and ethnic discrimination in the United States has been detrimental to the health of countless Americans. Several critical issues involving systemic racism and disparities in health care are examined in this article. Part II explores the impact of racial and ethnic discrimination on the physical and mental health of African Americans and others including White Americans. From slavery to lynching to incarceration many generations of African American families have endured trauma. Psychologists and other social scientists have discovered through their research and studies that these continuing experiences with racism and observations of such may be the cause of a significant number of race-based physical health disparities. Historically, numerous African Americans have been unfavorably impacted by police misconduct, which has led to adverse health (both mental and physical) due to fear of law enforcement officials and brutality.

Part III presents a discussion of racial disparities in the provision of health care. This section focuses on distrust of medical professionals by African Americans, racial and ethnic bias among health care professionals, and statistical data and case studies involving alleged discriminatory medical care. African Americans, other minorities, and the poor have historically been subjected to health care neglect and abuse. Court opinions addressing matters of alleged race discrimination by health care professionals and medical institutions is addressed in Part IV of this article. Finally, Part V focuses on the racial and ethnic disparities related to the COVID-19 pandemic. Studies conducted by the Center for Disease Control and Prevention (CDC) and its efforts to correct the disparities are discussed along with remedies proposed by the American Association of Retired Persons (AARP).

II. THE IMPACT OF RACIAL DISCRIMINATION ON THE PHYSICAL AND MENTAL HEALTH OF AFRICAN AMERICANS AND OTHERS INCLUDING WHITE AMERICANS

Historically, racial and ethnic bias in society has had an adverse impact on the physical and mental health of African Americans, Indigenous, and other persons of color. This may be due to persons either experiencing, witnessing or hearing about such conduct.[1] It has been observed that "[l]ong before Black people get 'sick', they are often ill with the remnants of systemic racism that expose them to stress and toxins that impact their ability to live safely and freely."[2] Not only do Black Americans suffer from systemic racism, it has been reported that racism has insidious or subtle harmful effects on the health of White Americans as well,[3] which will be addressed later in this section.

[1] *See* Joanne Lewsly, *What are the Effects of Racism on Health and Mental Health?*, Medical News Today (July 28, 2020), https://www.medicalnewstoday.com/articles/effects-of-racism.

[2] Rashawn Ray & Lawrence O. Gostin, *What are the Health Consequences of Systemic Racism?*, The Milbank Quarterly (May 25, 2021), https://www.milbank.org/quarterly/opinions/what-are-the-health-consequences-of-systemic-racism/.

[3] Heather Tirado Gilligan, *Why Racism is Terrible for Everyone's Health*, JSTOR Daily (Oct. 21, 2015), https://daily.jstor.org/why-racism-is-terrible-for-everyone-health-care/.

A. Health Consequences Of Societal Race Discrimination

An Associate Professor of Psychology, Dr. Evelyn J. Patterson, stated " '[f]rom slavery, to lynching, to incarceration, generations of African American families have endured having their family members taken away. [They] . . . have had to learn how to compartmentalize this trauma and have survived, in part, due to their resilience'." . . . . " 'But this resilience is a double-edged sword as these experiences worsen health outcomes.' "[4] Similarly, psychologists and other social scientists have suggested that these constant experiences with racial discrimination, and possibly social exclusion, may be the cause of a large number of well-documented race-based physical health disparities that affect this significant population.[5]

Dr. Joy DeGruy has written a book about Post Traumatic Slave Syndrome (PTSS) in which she describes her theory of PTSS. She refers to it as "a condition that exists as a consequence of multigenerational oppression of Africans and their descendants resulting from centuries of chattel slavery. A form of slavery which was predicated on the belief that African Americans were inherently genetically inferior to whites."[6] She states further that "[t]his was then followed by institutionalized racism which continues to perpetuate injury. Thus, resulting in M.A.P.:

- **M**: Multigenerational trauma together with continued oppression;
- **A**: Absence of opportunity to heal or access the benefits available in . . . society; [which] leads to
- **P**: Post Traumatic Slave Syndrome."[7]

Dr. DeGruy notes that from the time Africans were enslaved in the 16th century until the Emancipation Proclamation became effective in 1863 and the ratification of the Thirteenth Amendment in 1865, Africans were hunted like animals, sold as property, tortured, and raped. They were subjected to the worst type of physical, psychological, and spiritual abuse. In view of this history, there is a probability, which is more than a possibility, that a large number of the enslaved persons were severely traumatized, and that trauma, as well as its impact, continued beyond the abolition of slavery. Subsequent to Emancipation, African Americans experienced one hundred more years of institutionalized subjugation through such things as:[8]

(1) Black Codes (Restrictive laws that limited the liberty of Blacks to make sure they would be available to provide cheap labor, which could lead to arrest, fines, or forced unpaid labor if they refused to work);[9]

---

[4] Evelyn J. Patterson, *The Psychological Distress Endured by African American Women With Family Members in Prison*, J. Blacks Higher Educ. (Sept. 28, 2020), https://www.jbhe.com/2020/09/the-psychological-distress-endured-by-african-american-women-with-family-members-in-prison/.

[5] Vickie M. Mays, Susan D. Cochran & Namdi W. Barnes, Race, *Race-Based Discrimination, and Health Outcomes Among African Americans*, 58 Ann. Rev. Psych. 201 (Jan 2007), https://www.annualreviews.org/doi/abs/10.1146/annurev.psych.57.102904.190212?journalCode=psych.

[6] Joy DeGruy, Post Traumatic Slave Syndrome: America's Legacy of Enduring Injury and Healing (2005), https://www.joydegruy.com/post-traumatic-slave-syndrome.

[7] *Id.*

[8] *Id.*

[9] Black Codes (History.Com Editors, updated Jan. 21, 2021), https://www.history.com/topics/black-history/black-codes.

(2) Jim Crow Laws (Statutes that were passed on the state and local levels that legalized racial segregation which had the effect of denying Blacks the right to vote, to engage in certain employment and educational opportunities, and more. African Americans who defied the laws were many times arrested, fined, incarcerated, or subjected to violence or even death.);[10]

(3) Domestic Terrorism;[11] and

(4) Lynching.[12]

Key [Predictable] Patterns of Behavior Reflective of PTSS have been identified by Dr. DeGruy as the following:

> **Vacant Esteem**
> Insufficient development of what . . . [is referred] to as primary esteem, along with feelings of hopelessness, depression and a general self-destructive outlook.
>
> **Marked Propensity for Anger and Violence**
> Extreme feelings of suspicion perceived negative motivations of others. Violence against self, property and others, including the members of one's own group, i.e. friends, relatives, or acquaintances.
>
> **Racist Socialization and ([I]nternalized [R]acism)**
> Learned Helplessness, literacy deprivation, distorted self-concept, antipathy or aversion for the following:
> - The members of [one's] own identified cultural/ethnic group,
> - The mores and customs associated [with one's] own identified cultural/ethnic heritage,
> - The physical characteristics of [one's] own identified cultural/ethnic group.[13]

Although there has been overall improvement in the condition of the lives of African Americans over the years, poor health persists. It appears that discrimination has played a part in the health disparities that impact African Americans which arise from various sources, for example: "[1] cultural differences in life style patterns, [2] inherited health risks, . . . [3] social inequalities that are reflected in discrepancies in access to health care, [4] variations in health

---

[10] Jim Crow Laws (History.Com Editors, updated March 26, 2021), https://www.history.com/topics/early-20th-century-us/jim-crow-laws.

[11] Joy DeGruy, Post Traumatic Slave Syndrome: America's Legacy of Enduring Injury and Healing (2005), https://www.joydegruy.com/post-traumatic-slave-syndrome.

[12] *Id*. Additional ways African Americans experienced institutional subjugation were through *peonage* and *convict leasing*. "Peonage" is when a person is compelled "to perform labor in order to pay off a debt." William P. Statsky, Legal Thesaurus/Dictionary 568 (1985). "Convict Leasing" is a system that involves "forced penal labor." *See* William A. Todd, *Convict Lease System*, New Georgia Encyclopedia, last modified July 17, 2020, https://www.georgiaencyclopedia.org/articles/history-archaeology/convict-lease-system/.

[13] Joy DeGruy, Post Traumatic Slave Syndrome: America's Legacy of Enduring Injury and Healing (2005), https://www.joydegruy.com/post-traumatic-slave-syndrome.

providers' behaviors, [5] differences in socio-economic position . . . , and [6] residential segregation . . . ."[14] There exists a large number of disparities in health conditions and risk behaviors among African Americans and other people of color, namely diabetes, hypertension, asthma, obesity, tuberculosis, periodontitis, HIV/AIDS, cigarette smoking, early childbearing, low birth weight, and preterm births.[15] Additionally, early deaths result from an array of ailments including hypertension, diabetes, obesity and cardiovascular heart disease which disproportionately affect Blacks.[16]

Studies have shown that even perceived racial discrimination—the anticipation of being treated badly or unfairly—has a powerful impact on individuals, which can raise one's blood pressure. Discrimination has also been linked to increased incidents of alcohol consumption, binge drinking, at-risk drinking, smoking, drug use, poor sleep, and unhealthy eating habits in order to cope with discrimination-related stress, which in turn adversely affects health status.[17] Many African Americans live in neighborhoods where the status of the residents are predominantly minority (racial or ethnic), poor, or immigrant. The persons that live in those communities have many social problems which heightens the chances that they will be exposed to greater stress and also have less funds or other means with which to manage such exposures.[18]

Three pathways have been identified by which racial, ethnic or poor communities can have an impact on the health of individuals. First, adequate health and social services are less likely to be available to poorer communities, thereby resulting in a problem of access to and timely use of those services. Second, because of the environments in which these impoverished people reside, their exposure to health hazards is more likely. Examples of those hazards include exposure to "air pollution, lead, dust, dirt, smog," and other dangerous conditions. Third, such a concentration of impoverished residents and its related characteristics, such as "exposure to drugs, crime, gangs, . . . violence, unemployment, stress, . . . anxiety, substandard housing and schools, and lack of green space or fresh fruits and vegetables" frequently creates environments that reduce social relationships and provide the residents with less social benefits.[19]

Studies have also been conducted to determine the connection between race-based discrimination and how the brain functions. It has been stated that "[b]iological measures of race-based stress (allostatic load) reveal intricate relationships among the brain, immune system, autonomic nervous system, and the hypothalamic-pituitary adrenal (HPA) axis . . . , as well as the

---

[14] William Hall, Mimi Chapman & Tamera Coyne-Beasley, *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systemic Review*, 105 Am. J. Pub. Health 12 (Dec. 2015).

[15] *Id.*

[16] Vickie M. Mays et al., *Race, Race-Based Discrimination, and Health Outcomes Among African Americans*, 58 Ann. Rev. Psych. 201 (Jan. 2007), https://www.annualreviews.org/doi/abs/10.1146/annurev.psych.57.102904.190212?journalCode=psych.

[17] *Id. See also* Joanne Lewsly, *What are the Effects of Racism on Health and Mental Health?*, Medical News Today (July 28, 2020), https://www.medicalnewstoday.com/articles/effects-of-racism; David R. Williams, Jourdyn A. Lawrence, Bridgette A. Davis & Cecilia Vu, *Understanding How Discrimination Can Affect Health*, 54 Health Serv. Res. 1374 (2019), https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.13222.

[18] Vickie M. Mays et al., *Race, Race-Based Discrimination, and Health Outcomes Among African Americans*, 58 Ann. Rev. Psych. 201 (Jan. 2007), https://www.annualreviews.org/doi/abs/10.1146/annurev.psych.57.102904.190212?journalCode=psych.

[19] *Id.*

ways in which unhealthy environmental stimuli can 'get under the skin' of individuals to cause negative health outcomes . . . ."[20] A study performed by the University of California, Santa Barbara (UCSB) proposes that for those individuals who are subjected to discriminatory attitudes, such as negative stigmatization or stereotyping, dealing with such attitudes may actually modify the functioning of the brain.[21]

Dr. Monica Hinton, a Behavioral Health Therapist, described an event that she said caused "enduring damage" to the African American community, both psychologically and economically. That event was the "Massacre of Black Wall Street," which has been called "the deadliest recorded act of racial aggression in U. S. history." This devastation took place in 1921 in Tulsa, Oklahoma's Greenwood District, known as Black Wall Street, which was considered one of the most affluent African American communities in the United States.[22] The following is a brief description of the Greenwood District tragedy that was a likely contributor to the adverse impact of racial discrimination on the physical and mental health of African American people:

> [On May 31, 1921], the Tulsa Tribune reported that a black man, Dick Rowland, attempted to rape a white woman, Sarah Page. Whites in the area refused to wait for the investigative process to play out, sparking two days of unprecedented racial violence. Thirty-five city blocks went up in flames, 300 people died, and 800 were injured. [Also, 9,000 people were left homeless.] Defense of white female virtue was the expressed motivation for the collective racial violence. Accounts vary on what happened between Page and Rowland in the elevator of the Drexel Building. Yet as a result of the *Tulsa Tribune*'s racially inflammatory report, black and white armed mobs arrived at the courthouse. Scuffles broke out, and shots were fired. Since the blacks were outnumbered, they headed back to Greenwood. But the enraged whites were not far behind, looting and burning businesses and homes along the way.[23]

Dr. Monica Hinton asserts that the preceding events "add to Post Traumatic Slave Syndrome," a term discussed earlier in this article as "the multigenerational trauma and injustices experienced by African Americans—from the dawn of slavery to the recent deaths of Black citizens at the hands of police."[24] Although there can be no comparison of the horrendous effects of racism on people of color versus White persons, race-based discrimination harms everyone. Regarding the costs to White people, they have reported often feeling dehumanized and burdened by racism in the following ways:[25]

---

[20] *Id.*

[21] Robby Berman, *Racial Stigmatization May Change the Brain*, Medical News Today (July 13, 2020), https://www.medicalnewstoday.com/articles/racial-stigmatization-may-change-the-brain.

[22] Monica Hinton, *Understanding Post Traumatic Slave Syndrome*, Sharp HealthCare (June 19, 2020), https://www.sharp.com/health-news/understanding-post-traumatic-slave-syndrome.cfm. *See also* Kimberly Fain, *The Devastation of Black Wall Street*, JSTOR Daily (July 5, 2017), https://daily.jstor.org/the-devastation-of-black-wall-street/.

[23] *Id.*

[24] Monica Hinton, *Understanding Post Traumatic Slave Syndrome*, Sharp HealthCare (June 19, 2020), https://www.sharp.com/health-news/understanding-post-traumatic-slave-syndrome.cfm.

[25] Massachusetts Conference United Church of Christ, *Racism Hurts Everyone—Costs to White People*, http://www.macucc.org/racismhurtseveryonecoststowhitepeople.

- [They] [e]xperience a sense of being cut off from people of color—of not belonging with, or being welcomed by, people of color (who are a majority of the world's population).

- [They] [h]ave stereotypes, prejudices, and negative thoughts about people of color, and feelings of superiority enter [their] . . . minds against [their] . . . will.

- [They] are deeply pained by learning about the suffering and inequities experienced by people of color as a result of racism.

- [They] [f]eel hopeless and powerless to create a just society in the face of racism.

- [They] [f]eel guilty about the history of racism and current racism.

- [They] [f]ear making mistakes and being seen as racist.

- [They often have their] integrity eroded and [their] . . . sense of goodness and self-worth undermined by [their] . . . failures to stand up against racism.

- [They] [e]xperience unjustified fears of people of color.

- [They] are [s]eparated from other white people by feelings about race.

- [They] are [s]eparated from people of color who are working class and poor, who are [their] . . . natural allies, with whom [they] . . . could join forces to bring about a more equitable distribution of wealth that could benefit us all.

- [They] [e]xperience unfounded fears of what people of color may do to white people when they have the power to exact revenge or retribution for racism.

- [They] [m]iss out on the benefits of deep human relationships with people of other 'races' and cultures, and all that can be learned and enjoyed in such relationships.[26]

B. Health Consequences Of Police Misconduct

There are many police officers who serve the public honorably, and are ethical, hardworking, respectful and caring. However, historically, African Americans' lives were plagued by fear of being harmed by law enforcement officials "who monitored their every behavior, attacked them on the street[s] and in their homes, and killed them for the slightest alleged

[26] *Id*.

provocation."[27] There were White men who voluntarily organized themselves into groups called slave patrols who helped set into motion hundreds of years of violent and racist conduct aimed at African Americans resulting in protest marches and uprisings against police brutality. Runaway slaves were hunted down by the slave patrols, and those persons whether Black or White, who tried to assist the escapees were attacked. In 1702, for instance, the state of South Carolina authorized its first slave patrol followed by Virginia (1726) and North Carolina (1753). Slave patrols ended after the abolition of slavery in 1865 with the passage of the Thirteenth Amendment, and they were replaced with more modern police departments. However, African Americans were still subjected to heavy police authority, especially in jurisdictions that enacted Black Codes or laws that restricted employment, ownership of property, and other conduct.[28]

African American communities were terrorized by the Ku Klux Klan (KKK) and other hate groups, which included some police officers and other government officials who joined the KKK. Lynchings and destruction of Black schools were carried out by these groups frequently with the active assistance or empathy of law enforcement. Police brutality also occurred during the civil rights era when Blacks and others protested against segregation and other racist laws which involved the use of dogs and fire hoses against the protestors.[29]

Ehrlichman, former counsel and Domestic Policy Chief for President Nixon, confirmed in an interview with Harper's Magazine that Nixon's war on drugs, which was initiated in 1971 and resulted in increased arrests and more severe prison sentences mostly aimed at Blacks, "was designed to hurt [B]lack families."[30] John Ehrlichman "told Harper's Magazine 'We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news.' "[31]

One author cited Khalil Gibran Muhammad, an historian, who stated the following in his book:

> Police patrolled Black neighborhoods and arrested Black people disproportionately; prosecutors indicted Black people disproportionately; juries found Black people guilty disproportionately; judges gave Black people disproportionately long sentences; and, then, after all this, social scientists, observing the number of Black people in jail, decided that, as a matter of biology, Black people were disproportionately inclined to criminality.[32]

---

[27] Wenei Philimon, *Not Just George Floyd: Police Departments Have 400-Year History of Racism*, USA Today (June 7, 2020), https://www.usatoday.com/story/news/nation/2020/06/07/black-lives-matters-police-departments-have-long-history-racism/3128167001/.

[28] *Id*. *See also* Jill Lepore, *The Invention of the Police*, New Yorker Magazine (July 13, 2020), https://www.newyorker.com/magazine/2020/07/20/the-invention-of-the-police.

[29] Wenei Philimon, *Not Just George Floyd: Police Departments Have 400-Year History of Racism*, USA Today (June 7, 2020), https://www.usatoday.com/story/news/nation/2020/06/07/black-lives-matters-police-departments-have-long-history-racism/3128167001/.

[30] *Id*.

[31] *Id*.

[32] *See* Jill Lepore, *The Invention of the Police*, New Yorker Magazine (July 13, 2020), https://www.newyorker.com/magazine/2020/07/20/the-invention-of-the-police (citing Kahlil Gibran Muhammad, *The Condemnation of Blackness: Race, Crime, and the Making of Modern Urban America* (2010)).

Systemic racial inequality and police officer mistreatment of Black Americans in the United States, past and present, aggravates morbidity and mortality for this significant ethnic group. Blacks are 3.5 times more likely to be killed by police compared with Whites in situations where Blacks do not have weapons or are not the ones attacking. Regarding young Black men, one paper estimates there is a probability that 1 in 1000 of them will be killed by police during the course of a lifetime. Unjustified killings, racial profiling, and the use of force generally by police against Blacks are harmful to their health.[33] The adverse impact of police violence on the health of Black communities has been said to be a reason to treat such racially unequal conduct as a public health issue. A study conducted by Abigail A. Sewell, Associate Professor of Sociology at Atlanta, Georgia's Emory University, discovered a connection "between 'living in minority communities with a high concentration of use of force by police against pedestrians' and a higher risk of diabetes and obesity." Negative physical and mental effects ensue when there is a fear of violent encounters with police due to stress which some experts refer to as falling "within the larger scheme of structural racism." Trauma, anxiety and hopelessness are also stressors linked to the fear of future police violence in society or via news reports that may cause heightened stress when the persons killed are unarmed, and the killings are perceived as unwarranted.[34] Similar to the health consequences of societal race discrimination on the health of Blacks and others, there is a spillover effect of adverse mental health on other persons in the community who are not directly impacted by police violence. Research was conducted that analyzed the mental health consequences to Black and White Americans who hear about or witness the police killing of a Black American. The data and conclusion stated below are from a study co-authored by Professor David R. Williams.[35]

> The study examined the mental health of 38,993 Black adults—out of an initial sample of 103,710 respondents—who had had exposure to one or more police killings of unarmed Black Americans in the 3 months leading up to the study.
>
> The researchers used a mental health assessment score that counted "poor mental health days" among Black and [W]hite Americans. They found that with each additional police killing of an unarmed Black American, Black respondents were more likely to report additional "poor mental health days."
>
> This likelihood was reflected in "0.14 additional poor mental health days" for each killing among Black American respondents.
>
> By contrast, "Mental health impacts were not observed among [W]hite respondents and resulted only from police killings of unarmed [B]lack Americans (not unarmed [W]hite Americans or armed [B]lack Americans)."
>
> The authors concluded:

[33] Rashawn Ray & Lawrence O. Gostin, *What are the Health Consequences of Systemic Racism?*, The Milbank Quarterly (May 25, 2021), https://www.milbank.org/quarterly/opinions/what-are-the-health-consequences-of-systemic-racism/.
[34] Ana Sandoiu, *Police Violence: Physical and Mental Health Impacts on Black Americans*, Medical News Today (June 22, 2020), https://www.medicalnewstoday.com/articles/police-violence-physical-and-mental-health-impacts-on-black-americans.
[35] *Id*.

> "Police killings of unarmed [B]lack Americans have adverse effects on mental health among [B]lack American adults in the general population. Programs should be implemented to decrease the frequency of police killings and to mitigate adverse mental health effects within communities when such killings do occur."[36]

A few scholars have proposed various changes that may reduce the unjustified use of force by police officers and improve accountability. This in turn will likely lessen the harmful physical and mental health consequences to Blacks, as well as other Americans. Examples include: (1) more investment of funds into mental health programs; (2) increase funding for public education; (3) development of drug prevention programs; (4) investment of resources to prevent homelessness; (5) investment of funding to create community-centered crime prevention programs; (6) use of greater resources for jobs development;[37] (7) rigorous requirements for the wearing of bodycams; (8) immediate disclosure of the bodycam videos; (9) increased transparency regarding officers' disciplinary records; (10) information about police contracts; (11) police union information; (12) creation of community oversight boards with subpoena authority to review police misconduct; (13) hotlines for reporting police wrongdoing; and (14) the elimination of qualified immunity which is a federal doctrine that insulates state and local government officials, including law enforcement officers, *unless* they are determined to have violated an individual's "clearly established statutory or constitutional rights."[38]

III. RACIAL DISPARITIES IN THE PROVISION OF HEALTH CARE

Encountering discrimination, as a patient in the American medical system, has historically been a common occurrence for many African Americans, the poor, and other people of color. Although most patients are probably in danger of experiencing some difficulties in terms of their well-being, independence or liberty during and at the end of their lives, many people agree that members of certain racial, economic and/or other groups are especially vulnerable, and therefore require legal protection.[39] It has been noted that some African Americans, other minorities, and the poor have customarily been subjected to health care abuse and have had their preferences for certain medical benefits or treatments either ignored or never solicited by their physicians.[40] The sections below focus on the following topics: reasons for many African Americans' suspicious attitudes towards medical professionals; racial bias among health care professionals generally; and statistical data and case studies involving unequal medical care.

---

[36] *Id*.

[37] Malaika Jabali, *If You're Surprised by How the Police are Acting, You Don't Understand U.S. History*, Guardian News and Media (June 5, 2020), https://www.theguardian.com/commentisfree/2020/jun/05/police-us-history-reform-violence-oppression.

[38] Sarah R. Guidry, *Police Misconduct and Qualified Immunity: Reimagining "We the "People" Conference Introduction*, 6 The Bridge: Interdisciplinary Perspectives on Legal and Social Policy 1 (Article 1: 2021), https://digitalscholarship.tsu.edu/thebridge/vol6/iss1/1/. *See also* Emma Tucker, *States Tackling 'Qualified Immunity' for Police as Congress Squabbles Over the Issue*, CNN (April 23, 2021), https://www.cnn.com/2021/04/23/politics/qualified-immunity-police-reform/index.html.

[39] 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, 1018 (1998).

[40] *Id*. at 1020.

A. Distrust Of Medical Professionals

Since many African Americans have experienced disrespect in general for their independence and liberty by being abused, neglected or exploited, when they do have encounters with the health care system, they feel that they are being treated differently on the basis of race only. Many are suspicious of physicians and are concerned about giving them too much authority in dealing with their medical needs.[41] Due to the existence of a number of stereotypes about African Americans and other minorities, in the minds of the public, which are probably being repeated by numerous individuals on a daily basis, many medical professionals and others form negative attitudes toward certain ethnic groups. Often, this results in many African Americans being subjected to discrimination that is harmful without the medical professional being consciously aware that her or his conduct is motivated by racism.[42] These stereotypes frequently entail "sexual promiscuity, [inferior] intellectual performance, or susceptibility of blacks to disease and vice."[43]

African Americans have been labeled inferior as a group partly because of the crucial role medicine has played in providing information from various studies that promote opinions concerning biological dissimilarities seen in distinctions "in skin color, hair, appearance, and behavior between" African Americans and White persons.[44] This was said to have essentially established the superiority of Whites.[45] According to one writer, the medical development of these racial differences and interest in the health status of African Americans historically was prompted by the "self-interest of [W]hites rather than the needs of African Americans."[46]

B. Racial And Ethnic Bias Among Health Care Professionals Generally

African Americans, as well as other people of color and the poor in the United States, have customarily been subjected to health care abuse and have had their preferences for certain medical benefits or treatments either ignored or never solicited by their physicians.[47] These groups encounter disparities, not just concerning access to medical care, but also: in the quality of care received; in health outcomes like preventing a person's death after a stroke or enhanced eye sight following glaucoma surgery; in the incidence and prevalence of disease; life expectancy; and mortality. Regarding access to health care, people of color compared with White Americans are confronted with more obstacles to medical services, including "preventive services, acute

[41] *Id*. at 1023. *See also* Mohsen Bazargan, Sharon Cobb & Shervin Assari, *Discrimination and Medical Mistrust in a Racially and Ethnically Diverse Sample of California Adults*, Annals of Fam. Med. 4, 9-12 (2021), https://www.annfammed.org/content/annalsfm/19/1/4.full.pdf (discussing statistics from studies showing a much higher level of mistrust that African American and Hispanic participants feel towards health care professionals compared with the White participants).
[42] 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, 1024 (1998).
[43] *Id*. at 1030.
[44] *Id*. at 1025-26.
[45] *Id*. at 1026.
[46] *Id*.
[47] *Id*. at 1020.

treatment, and chronic disease management."[48] In view of these obstacles encountered by people of color, ordinarily their level of satisfaction when interacting with health care providers is low. According to a National Healthcare Disparities Report, "White patients received better quality of care than Black American, Hispanic, American Indian, and Asian patients. Dominant communication styles, fewer demonstrated positive emotions, infrequent requests for input about treatment decisions, and less patient-centered care seem to characterize patient-provider interactions involving people of color."[49]

The attitudes of health care providers towards patients vary. Some medical professionals possess subtle biases that are expressed in various ways, which may be caused partly or totally by positive or negative attitudes they hold toward persons of certain races.[50] Examples of ways that providers express their subtle biases include the following:

> Approaching patients with a dominant and condescending tone that decreases the likelihood that patients will feel [that they are being] heard and valued . . . , failing to provide interpreters when needed, doing more or less thorough diagnostic work, [and] recommending different treatment options for patients based on assumptions about their treatment adherence capabilities, and granting special privileges, such as allowing some families to visit patients after hours while limiting visitation for other families.[51]

In addition to the preceding expressions of subtle biases, some White health care providers view African American patients as being "less intelligent, less able to adhere to treatment regimens, and more likely to engage in risky health behavior than their White counterparts."[52]

Medical research and experimentation are also areas where Black Americans have been subjected to discrimination, abuse or exploitation. Doctors have used Blacks as specimens for clinical teaching and public displays.[53] Dead bodies of Blacks have also been used by White doctors for the purpose of dissecting and conducting autopsies on those bodies even though there was opposition from members of the public to those procedures being performed on their own loved ones. Unfortunately, since Blacks were not in any position to safeguard their deceased family members and significant others, some White doctors utilized Black bodies for practice.[54] Medical colleges in the South were known to boast about how "their cities' large [B]lack populations provided ample supplies of clinical and anatomical material."[55]

---

[48] William Hall, Mimi Chapman & Tamera Coyne-Beasley, *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systemic Review*, 105 Am. J. Pub. Health 12 (Dec. 2015).
[49] *Id.*
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] 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, 1026 (1998).
[54] *Id.*
[55] *Id.*

An experiment that began in 1932 and lasted for forty years was the Tuskegee Syphilis Study that involved 399 to 400 poor and barely educated Black male subjects. This study involved observing the effects of untreated syphilis on Black males. These men were experimented on without their consent, and when penicillin, an effective medical treatment became available, it was not given to them. However, the men were tricked into believing they were receiving treatments by the physician who directed the study.[56]

C. Statistical Data And Case Studies Involving Alleged Racial Disparities In Medical Care

STATISTICAL DATA

Racial and ethnic disparities in health care may be the cause of injuries and deaths for some members of racial and ethnic minorities who, unfortunately, happen to be victims of the injustices of the American health care system.[57] For instance, in a study where the participants' income levels and medical insurance program are the same, those individuals, who are members of racial and ethnic minority groups, frequently receive a lesser quality of health care than those of European descent.[58] The following are examples of the results of various studies that support claims of racial and ethnic bias in the medical profession:

Pain Management
(Undertreatment of Pain in Black People)

In a 2016 study of racial bias and pain management, a link was found "between undertreating pain in Black patients and false biological beliefs, such as, 'Black people's skin is thicker than [W]hite people's skin.' "[59]

Pain Management
(Failure to Administer Pain to Black Children with Severe Appendicitis Pain)

A 2015 study found that Black children compared with people of other races who suffered severe appendicitis pain are "less likely to receive pain medication." This finding indicates "that racial bias is causing medical professionals to use different thresholds of pain for different racial groups, either inadvertently or purposefully, before administering care."[60]

---

[56] *Id*. at 1026-30. *See also* Walter T. Champion, *The Tuskegee Syphilis Study as a Paradigm for Illegal, Racist, and Unethical Human Experimentation*, 37 S. U. L. Rev. 231, 231 & 242 (2010); Ruqaiijah Yearby, *Exploitation in Medical Research: The Enduring Legacy of the Tuskegee Syphilis Study*, 67 Case W. Res. L. Rev. 1171 (2016).

[57] Peter A. Clark, *Prejudice and the Medical Profession: A Five-Year Update*, 37 J. L. Med. Ethics 118, 118 (2009).

[58] *Id*. at 118 & 124 (citing Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Institute of Medicine, *Unequal Treatment: What Healthcare Providers Need to Know About Racial and Ethnic Disparities in Health Care* (Washington, D.C. Academy Press 2002).

[59] Joanne Lewsly, *What are the Effects of Racism on Health and Mental Health?*, Medical News Today (July 28, 2020), https://www.medicalnewstoday.com/articles/effects-of-racism. *See also* Robby Berman, *90% of U.S. Primary Care Offers Lower Pain Relief Doses to Black Patients*, Medical News Today (July 30, 2021) ("The U.S. medical system provides less pain relief to Black patients than [W]hite patients and this has been the case for decades."), https://www.medicalnewstoday.com/articles/90-us-primary-care-offers-lower-pain-relief-doses-black-patients.

[60] Joanne Lewsly, *What are the Effects of Racism on Health and Mental Health?*, Medical News Today (July 28, 2020), https://www.medicalnewstoday.com/articles/effects-of-racism.

Clinical Trials
(Underrepresentation of Ethnic Minorities in Clinical Trials Involving New Medications for HIV)

African Americans and other ethnic minorities were reported to have been significantly underrepresented in clinical trials involving new medications for the virus that causes Acquired Immunodeficiency Syndrome (AIDS) even though these minority groups comprised an increasing percentage of Americans who contracted the virus. African Americans were approximately one-half as likely as Whites to participate in the Human Immunodeficiency Virus (HIV) trials and be treated with experimental medications.[61]

Human Experimentation Without Consent
(Belief that African Americans are More Likely to be Used as Guinea Pigs)

A study revealed that African Americans were 79.2% more likely to believe that persons like them would be utilized as guinea pigs without permission compared with only 51.9% of Whites who were questioned.[62]

Human Experimentation
(Belief that Medications are Prescribed for the Purpose of Conducting Experiments Without Consent)

African Americans (at a rate of 62.8%) compared with 38.4% of Whites believed that doctors frequently prescribed medicines in order to conduct experiments on people without getting their permission.[63]

Treatment Of Certain Ailments
(Lower Probability that Minorities Will Receive Essential Medical Services)

As to necessary medical procedures, the huge majority of the more controlled studies revealed that minorities have a lower probability than Whites of receiving essential services,[64] which comprise treatment of ailments such as: "cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness."[65]

Unconscious Bias
(Implicit Negative Racial and Stereotypical Attitudes About Minorities)

A substantial amount of empirical evidence has shown that White doctors who have good intentions, are *not* openly biased and who do *not* think they are prejudiced normally indicate[66]

[61] Peter A. Clark, *Prejudice and the Medical Profession: A Five-Year Update*, 37 J. L. Med. Ethics 118, 118 (2009).
[62] *Id. See also* Giselle Corbie-Smith et al., *Distrust, Race and Research*, 162 Archives of Internal Medicine 2458 (2002).
[63] Peter A. Clark, *Prejudice and the Medical Profession: A Five-Year Update*, 37 J. L. Med. Ethics 118, 118 (2009). *See also* Giselle Corbie-Smith et al., *Distrust, Race and Research*, 162 Archives of Internal Medicine 2458 (2002).
[64] Peter A. Clark, *Prejudice and the Medical Profession: A Five-Year Update*, 37 J. L. Med. Ethics 118, 124 (2009).
[65] *Id*.
[66] *Id*.

"unconscious implicit negative racial attitudes and stereotypes."[67] Interpersonal interactions are significantly impacted by stereotypes that are both implied and express.[68]

Verbal Interaction With Health Care Providers
(Poor Communication Between Low Income Children and Providers)

Concerning verbal interactions with health care providers, poor children compared with upper "income children were over 28% more likely to experience poor communication with . . . [those] providers."[69] The children referred to here include African Americans and others.

Mental Illness
(Serious Untreated Depression)

African Americans compared with Whites are more likely to experience serious, untreated, and incapacitating depression.[70]

Medical Trials And Research
(Less Requests for Minority Participation)

According to a National Institutes of Health study released in 2005, minorities and Whites were equally willing to take part in medical trials and research, but minorities received less requests for their participation.[71]

Medical Treatment
(African American Patients with Diabetes)

As to medical treatment for diabetes mellitus, a study revealed that African American patients frequently experienced the worse results compared with White patients.[72]

Research and Experimentation
(Participation, Lack of Information, and No Consent)

According to a 2008 Johns Hopkins University study, researchers confirmed the following statistics from previous research projects:[73]

> >24% of black Americans reported that their doctors would not fully explain research participation to them, versus 13% of whites.
> >72% of black Americans said doctors would use them as guinea pigs without their consent, versus 49% of whites.
> >35% of black Americans said doctors would ask them to participate in research even if it could harm them, versus only 16% of whites.

---

[67] *Id*.
[68] *Id*.
[69] *Id*. at 125.
[70] *Id*.
[71] Peter A. Clark, *Prejudice and the Medical Profession: A Five-Year Update*, 37 J. L. Med. Ethics 118, 124 (2009).
[72] *Id*. at 125.
[73] *Id*. at 127-28.

>8% of black Americans more often believed they could less freely ask questions of doctors, compared to 2% of whites.
>58% of black Americans said doctors had previously experimented on them without consent, compared with 25% of whites.

Risk of Disease
(Advanced Cancer Regardless of Insurance Status)

Regardless of the insurance status of African American and Hispanic patients, the American Cancer Society statistics showed that these two minority groups still had a heightened risk of having an advanced phase of cancer—normally stage III or IV—at the point of diagnoses.[74]

Treatment of Disease
(Therapy for Various Cancers)

Statistics have shown that regardless of the stage of the disease, "African American patients were less likely than [W]hite patients to receive therapy for cancers of the lung, breast, colon, and prostrate . . . ."[75]

Hospital Admissions
(Treatment of Pediatric Disease)

Regarding hospital admissions for pediatric gastroenteritis disease, statistics showed that African Americans were 15% less likely than Whites to be admitted for treatment.[76]

Medical Services
(Heart and Pain Medications, Referrals, and Surgeries)

Studies demonstrate that African Americans are less likely than Caucasians to receive heart and pain medications, cardiac catheterization referrals, and glaucoma surgeries.[77]

Physicians' Perceptions Of African American Patients
(Assessment of African Americans' Intelligence and Education)

One study of physicians' perceptions revealed that African American patients in particular are assessed by physicians as: "less intelligent, less educated, and more likely to fail to comply with [their physicians'] medical advice. . . ."[78]

[74] *Id*. at 128.
[75] *Id*.
[76] *Id*.
[77] Ruqaiijah Yearby, *Does Twenty-five Years Make a Difference in "Unequal Treatment"?: The Persistence of Racial Disparities in Health Care Then and Now*, 19 Annals of Health L. 57, 57 (2010).
[78] *Id*. at 59.

Effect Of Patients' Race On Health Care Provider (Physicians' Subconscious Preference)

Health care providers in general have been shown to be affected by the race of their patients, and subconsciously physicians prefer Caucasian patients over African American patients as indicated in a 2008 study that investigated implicit and explicit viewpoints of physicians.[79]

Impact Of Discriminatory Health Care Experiences (Mistrust, Avoidance, Poor Health Outcomes, and Others)

Researchers have found that discriminatory health care experiences have caused: " 'delay in seeking care, and interruption in continuity of care, non-adherence, mistrust, reduced health status, and avoidance of the healthcare system.' "[80] In addition to preventing African Americans from obtaining health care services, racial discrimination has resulted in African Americans experiencing poor health outcomes, such as larger numbers of infant deaths.[81]

Diabetes Treatment (Amputation of Lower Limb)

Concerning the amputation of all or part of a lower limb, African Americans have been shown to more likely than Whites experience amputation of all or part of a lower limb due to diabetes mellitus, which is the most common rationale for such a procedure. This likelihood of amputation was found to be three and a half times greater than in the case of Whites although diabetes mellitus was merely 1.7 times as prevalent in older African Americans.[82]

Quality of Care In Similar Hospitals (Poorer Treatment Received by African Americans)

Evidence has shown that African Americans are more likely to receive a poorer quality of treatment than Whites although they are receiving the treatment in similar hospitals.[83]

Impact Of Patient's Speech On Physicians (Poor English and Quality of Medical Treatment)

One doctor-patient study showed that African Americans who speak poorer English (otherwise referred to as "Black English") tend to receive: the "worst [medical] service, are considered ignorant [by doctors], and are told what to do rather than [being] asked what they would like to do."[84]

---

[79] *Id*.
[80] *Id*.
[81] *Id*. at 59-60.
[82] 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, 1035 (1998).
[83] *Id*.
[84] *Id*. at 1037.

Black-White Disparities Involving Mortality (Worsening of Inequalities and Excess Minority Deaths)

Reports have shown a worsening in racial inequalities in health care since 1985. Researchers found in 1985 that, compared with Whites, minorities sustained 60,000 excess deaths. This figure expanded to 83,570 by 2005.[85] Indeed, there has *not* been any " 'sustained decrease in black-white disparities in age-adjusted mortality (death) or life expectancy at birth at the national level since 1945'."[86]

Insurance Coverage (Disparities in Insurance Coverage Among Various Ethnic Groups)

A scholar wrote in 2011 that "[p]eople of color comprise one-third of the United States population, but of the 45.7 million non-elderly Americans who were uninsured in 2008, more than half (55%) were minorities."[87] Precisely, "32% of Latinos were . . . uninsured, 28% of Native Americans were . . . uninsured, and 21% of African Americans were . . . uninsured, compared to 13% of Caucasians. Additionally, public health care programs like Medicaid disproportionately serve[d] minorities."[88] Since minorities usually work in low paying jobs, they are less likely to receive medical coverage through their employers than White Americans.[89]

Data from a 2019 study of health coverage of nonelderly population (ages 0 to 64) by race and ethnicity revealed that 8% of Whites were uninsured, 11% of Blacks were uninsured, 20% of Hispanics were uninsured, 7% of Asians were uninsured, 22% of American Indians and Alaska Natives (AIAN) were uninsured, and 13% of Native Hawaiians and Other Pacific Islanders (NHOPI) were uninsured.[90]

In view of the preceding statistical data collected from various studies, one scholar has discussed racial disparities in health care and its connection to structural racism in the United States. Structural racism has been referred to as "the power used by the dominant group to provide members of . . . [that] group with advantages, while disadvantaging the non-dominant group . . . . The dominant group uses structural racism not only to obtain resources, such as wealth, employment, . . . and healthcare, but also to limit the non-dominant group's access to these resources."[91] Consequently, in addition to the various studies previously discussed in this section, a national survey has shown that more than 70% of African American physicians reported experiencing racial bias at their place of employment, and another study revealed that 62% of

[85] Ruqaiijah Yearby, *Does Twenty-five Years Make a Difference in "Unequal Treatment"?: The Persistence of Racial Disparities in Health Care Then and Now*, 19 Annals of Health L. 57, 58 (2010).
[86] *Id.*
[87] Ruqaiijah Yearby, *Racial Inequities in Mortality and Access to Health Care*, 32 J. Legal Med. 77, 84 (2011) & n. 42 (citing Kaiser Fam. Found., The Uninsured: A Primer 5 (2009)).
[88] Ruqaiijah Yearby, *Racial Inequities in Mortality and Access to Health Care*, 32 J. Legal Med. 77, 84 (2011).
[89] *Id*. & n. 44 (citing Megan Thomas & Cara James, *The Role of Health Coverage for Communities of Color*, 4 (Kaiser Fam. Found. 2009)).
[90] Samantha Artiga, Latoya Hill, Kendal Orgera & Anthony Damico, *Health Coverage by Race and Ethnicity*, 2010-2019 (Kaiser Fam. Found. July 16, 2021), https://dir.md/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/?ned=us&host=www.kff.org.
[91] Ruqaiijah Yearby, *Racial Disparities in Health Status and Access to Healthcare: The Continuation of Inequality in the United States Due to Structural Racism,* 77 Am. J. Econ. & Socio. 1113, 1114 (2018).

physicians reported having witnessed a patient receiving poor quality medical care because of the race or ethnicity of that patient.[92]

Considering the disparities caused by structural racism in health care, in order to reduce or possibly eliminate the problem, the following proposals have been made by various scholars:

- [B]oth state and federal regulators should require healthcare facilities to conduct strategic diversity planning (Dreaschlin et al. 2013). The planning should include mandatory diversity courses for all hospital staff—including senior management staff—in which the policies and practices of the healthcare institution are reviewed for racial prejudice and discrimination. It should also require adoption of policies that have a zero tolerance for racial prejudice and discrimination that includes an automatic punishment for any infraction of the policy regardless of accidental mistakes, ignorance, or extenuating circumstances.[93]
- [S]everal reeducation practices [should be created] that can reduce the use of racial discrimination by physicians, such as self-awareness, intergroup contact, seeking counter-stereotypic images and imagery, developing emotional regulation skills by increasing positive emotions, empathy, and partnership building skills. [Van Ryn (2014:25)] Psychology research studies have shown that implicit racial bias can be changed through reeducation methods.[94]
- [H]ealthcare providers should be taught cultural humility. [Dr. Sana Loue] (2015:1417, 1418)]. The basic assumption of cultural humility training is that in every interaction with a patient, there is something healthcare providers neither know nor understand that cannot be answered through stereotyping. It can only be answered by expressing humility in each encounter with a patient to learn about that specific patient's needs and desires. Additionally, the explicit and implicit negative attitudes and behaviors that healthcare providers hold against African Americans can only be addressed through a development of critical consciousness, which requires "lifelong self-reflection, self critique, and learning" . . . .[95]
- Professor Verniellia Randall (2014:12-16), a racial health disparities expert, proposes adopting a new anti-discrimination law that would hold institutions and healthcare providers responsible for intentional, reckless, and negligent racial prejudice that affects African Americans' access to healthcare. The law would authorize and fund the use of medical testers and provide a private right of action both for individuals who are victims of racial prejudice and discrimination and for organizations that represent these individuals. Furthermore, each healthcare institution and healthcare provider would be responsible for submitting a racial equity report card that would be available online and in print to patients seeking care. When a healthcare institution or a healthcare provider . . . [is] sued and found guilty of violating the law, then that

[92] *Id*.
[93] *Id*.
[94] *Id*. at 1141.
[95] *Id*.

person or entity would be fined, subject to punitive damages, and required to pay attorney's fees.[96]

CASE STUDIES

Research indicates that racial discrimination occurs in the delivery of health care on various levels, which may involve the patient's financial status, educational standing, speech, appearance, lack of medical insurance, or other factors. Stereotypes, lack of respect, and misconceptions have also affected the quality of health care received by racial or ethnic minorities.[97] In response to the question "whether discrimination exists in receiving quality healthcare," one African American focus group participant stated: " 'The medical world just reflects the real world.' "[98] The case studies below are various experiences described by African Americans who participated in focus group discussions involving racial disparities in health care.

Participant "A"
(Stereotyping)

I've had both positive and negative experiences. I know the negative one was based on race. It was [with] a previous primary care physician when I discovered I had diabetes. He said, "I need to write this prescription for these pills, but you'll never take them and you'll come back and tell me you're still eating pig's feet and everything . . . . Then why do I still need to write this prescription." And I'm like, "I don't eat pig's feet." (African-American participant)[99]

Participant "B"
(Financial Status)

I know there have been a couple of times the doctor wanted to prescribe a certain medication but because of how much it was, he prescribed something else. Not what was best, but what I could afford. (African-American participant)[100]

Participant "C"
(Lack of Respect)

I felt that because of my race that I wasn't serviced as well as a Caucasian person was. The attitude that you would get. Information wasn't given to me as it would have [been given to] a Caucasian. The attitude made me feel like I was less important. I could come to the desk and they would be real nonchalant and someone of Caucasian color would come behind me and they'd be like, "Hi, how was your day?" (African-American participant)[101]

---

[96] *Id*. at 1142-43.
[97] Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care 392-402 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., The National Academies Press 2003).
[98] *Id*. at 392.
[99] *Id*. at 393.
[100] *Id*. at 395.
[101] *Id*. at 396.

Participant "D"
(Misdiagnosis or Erroneous Treatment)

The first thing they wanted to do was a hysterectomy. I was 36 years old and they never really examined me. I was just telling them the symptoms and it scared me and I left . . . . I guess they were trying to stop the population birth, whatever, because [the hospital] back then was for people who didn't have insurance. (African-American participant)[102]

Participant "E"
(Misdiagnosis or Erroneous Treatment)

My Ob-Gyn is Caucasian. I have fibroid tumors and the doctor I've been going to, he's been my Ob-Gyn for 14 years and for the last 2 years he told me I have to have this hysterectomy. I had a girlfriend at that office recommend me to a female African-American physician . . . . A week later she called me at home and said to me, "There is nothing wrong with you. The fibroid is there but if it's not bothering you, if it's not broke, don't fix it. You don't need to have a hysterectomy." (African-American participant)[103]

Participant "F"
(Appearance)

I've noticed that, outward appearance has a lot to do with the rapport that you have with your provider. They talk to you a little different, they treat you a bit differently. You can walk in, you're all battered and crummy looking, and their whole personality changes. You walk in looking half-way decent, and they're very pleasant, and they react and act completely different. (African-American participant)[104]

Participant "G"
(Financial Status and Lack of Insurance)

My niece went to this hospital and they wouldn't wait on her because she didn't have insurance. They told her she would have to go to the county hospital. So I had to take her to the county hospital. She was bleeding all the way. It was just terrible, because she didn't have insurance. (African-American participant)[105]

[102] *Id*. at 398.
[103] *Id*.
[104] *Id*. at 399.
[105] *Id*.

Participant "H"
(Improper Service or Misinformation)

> My daughter was young and I took her to the hospital. She had stomach pains. . . I went to this private doctor and hospital and they sent us home with some medicines. . . . The next day I sent her to school. The school called me up and said, "You [have] got to come pick up this child because she can't even walk." So I said, "OK, I'm going to County General because they will make sure this child's taken care of." I'm not going back playing with these people [at the private office]. I took her to County General. They had her in there for 5 hours checking everything. I found out that she had walking pneumonia. (African-American participant)[106]

The statements below were given by African American physicians who also participated in the focus group discussions. These comments reveal the physicians' observations of racial or ethnic disparities in the health care field.

Participant "I"
(Misdiagnosis or Erroneous Treatment)

> Of course, in psychiatry we see this (discrimination). One area we see is in terms of diagnosis. Patients are inappropriately diagnosed and medications prescribed for the patients. We see errors in that. Minority patients will often be diagnosed inappropriately as being schizophrenic. (African-American physician)[107]

Participant "J"
(Misdiagnosis or Erroneous Treatment)

> I'm in private practice and we refer a lot. We kind of know what specialists to avoid because we hear the patients coming back and telling about what type of treatment they're getting from these specialists. A lot of the specialists in these institutions act like they don't want to see the minority patient at all. When the minority patient ends up there maybe because they're on [a particular] plan . . . they are mistreated. (African-American physician)[108]

Participant "K"
(Institutional Discriminatory Policies and Methods)

> They would not take certain doctors from certain ZIP codes, but we found out what was going on and that subsequently has changed a few years ago. Because they didn't want [minority] patients, they just excluded people from certain ZIP codes, from certain sections of the city. (African-American physician)[109]

[106] *Id*. at 402.
[107] *Id*. at 397.
[108] *Id*.
[109] *Id*. at 402.

As illustrated in the preceding statements and opinions, the focus group participants often felt that misperceptions and stereotypes were the cause of the inferior quality of the medical care they received, not the reality of who they were as people. Also, the participants often believed that because of their race or culture, they were treated differently in that health care providers assumed they were poor, less educated or were less deserving of respect. Another automatic assumption by the health care providers revealed by participants in the focus group was that as soon as providers saw an African American or Latino patient, they believed the patient did not have insurance.[110] As a result of these assumptions on the part of many health care providers, there was concern or anxiety experienced by patients, such as the participants in these case studies, that they may receive a lower standard of care. Since the patients are racial or ethnic minorities, these types of assumptions involve the providers' beliefs about the types of medication and treatment these patients can afford. Consequently, the impact on the patient could be the provision of less effective medical treatment and medications, which could in turn adversely affect the patient's recovery.[111]

There were times when many patient participants in the focus group observed office medical staff members act in ways that manifested a lack of respect for racial minorities. Examples include times when the office staff "would not 'look [the patient] . . . in the eye' " when she or he spoke to the staff;[112] times when the staff "greeted other patients with a more pleasant attitude;"[113] times when the patient participants "were rushed during appointments and sensed that providers or their staff did not want to take the time to help them, answer their questions, or explain medical procedures to them;" and times when patients "felt they [had to] . . . wait for long periods of time before receiving medications and other medical assistance, while [white patients were] . . . cared for first."[114] It was clearly the belief of many focus group participants that ultimately the failure of health care providers to respect them would lead to a lower quality of health care services to racial and ethnic minority patients.[115]

Participants believed that health care providers' discriminatory attitudes and practices adversely affected the quality of treatment, namely misdiagnosis, improper treatment, mistreating racial and ethnic minorities in order to avoid having to treat them, and pressuring patients to have surgical procedures that were subsequently considered unnecessary by other physicians. It was recommended by a participant that in order to improve one's chances of receiving better medical care, one's voice and tone must be "strong" and not "humble."[116]

Some participants' claims of discrimination by health care workers were not overt. Therefore, in describing their experiences with discrimination, participants would simply say such things as "You can feel it" or "You just know."[117] To counteract discriminatory attitudes and conduct, some participants suggested that the patient improve her or his appearance by "being well-dressed" or "being presentable."[118]

---

[110] *Id*. at 392-93.
[111] *Id*. at 395.
[112] *Id*. at 396.
[113] *Id*.
[114] *Id*.
[115] *Id*.
[116] *Id*. at 398.
[117] *Id*.
[118] *Id*. at 399.

Lack of insurance or appearing not to be able to pay for health care services posed problems for some focus group participants. Instead of providing patients with appropriate care, physicians appeared to be more interested in insurance issues and whether they would receive payment for their services. Consequently, some physicians were perceived as not taking the time to listen to patients or not conducting proper medical examinations. Hopefully, the preceding beliefs, which include participants' reports about receiving improper medical service, misinformation, and passive treatment approaches,[119] will lead to equitable and greatly enhanced health care services in the near future.

IV. SELECTED COURT OPINIONS ADDRESSING ISSUES INVOLVING ALLEGED RACE DISCRIMINATION BY HEALTH CARE PROFESSIONALS AND MEDICAL INSTITUTIONS

The following is a small sampling of court opinions from various jurisdictions in which the courts addressed issues involving alleged civil rights violations, as well as other matters. Although some of the claimants' arguments received favorable treatment, many of the courts declined to find race discrimination by the defendant-medical professionals and institutions.

In one race discrimination case, the plaintiff-Okpor in *Okpor v. Kennedy Health System*,[120] alleged in his complaint various civil rights violations and a breach of contract claim against a New Jersey hospital and two of its doctor employees.[121] Plaintiff, who was experiencing pain and a headache, went to the Kennedy Hospital emergency room seeking medical care. Subsequent to meeting with a triage nurse, he was sent to one of the emergency room doctors who asked another female doctor to attend to plaintiff's health condition.[122] Afterwards, in the waiting room in the presence of his spouse and other individuals, one of the two doctors told the plaintiff "that the hospital did not treat black men from Africa with AIDS."[123] Plaintiff was refused medical care.[124] As a result of the doctor's public statement, the plaintiff "suffered embarrassment, humiliation, emotional distress [,] and pain and suffering."[125]

Assertions were also made by the plaintiff that the hospital should be held vicariously liable for the misconduct of its employees and agents, which was referred to as tortious in nature.[126] Furthermore, the plaintiff supported his claim against the hospital by stating that both doctors "were acting within the scope of their authority" at the time of the wrongful acts.[127] Additional allegations made by the plaintiff were that the hospital "as a place of public accommodation, has a duty to ensure that it does not discriminate against anyone seeking medical care."[128]

---

[119] *Id*. at 401.
[120] No. 10-1012, 2010 WL 3522784 (D.N.J. Sept. 2, 2010).
[121] *Id*. at *1.
[122] *Id*.
[123] *Id*.
[124] *Id*.
[125] *Okpor v. Kennedy Health System*, 2010 WL 3522784, at *1.
[126] *Id*.
[127] *Id*.
[128] *Id*. The court cited N.J.S.A. 10:5-12 (f)(1) which provides:

> It shall be an unlawful employment practice, or as the case may be, an unlawful discrimination, "[f]or any . . . place of public accommodation directly or indirectly to refuse, withhold from or deny

The United States District Court, New Jersey District, dismissed some of the plaintiff's claims because they were determined to be frivolous and failed to state sufficient causes of action.[129] However, leave was granted to amend the "defective" complaint as to sections 1982, 1983 and 1985 of Title 42 of the United States Code, but not section 1988.[130] The violations that were alleged under 42 U.S.C. § 1981 and breach of contract were reviewed by the court, and permission to proceed *in forma pauperis*" was granted to the plaintiff.[131]

In addressing the claim under section 1981 of the United States Code, the court in the *Okpor* case reasoned that this action for race discrimination had been sufficiently pled.[132] Generally, section 1981 "prohibits discrimination in the making and enforcement of contracts and property transactions."[133] More specifically, in order for a claim to be cognizable, thereby triable, under section 1981, the court stated that the following must be alleged: "(1) that the plaintiff is a member of a racial minority; (2) intent to discriminate on the basis of race by the defendant; and (3) discrimination concerning one or more of the activities enumerated in the statute, which includes the right to make and enforce contracts."[134] As indicated above, the alleged discrimination must be intentional,[135] and it should be noted that in the Third Circuit, it is inadequate if the intent is no more than a mere discriminatory impact or effect.[136]

The *Okpor* court concluded that all three section 1981 requirements outlined above were satisfied although the facts asserted by the plaintiff in support of requirement number two—intent to discriminate—was weak. As to requirement number one, the plaintiff qualified as "a member of a racial minority" group who had the right to seek medical care for his "pain and headache" from the Kennedy Hospital emergency room, a place of public accommodation.[137] Since the facts supporting the section 1981 requirement (number two) above concerning intentional discrimination were determined to be weak, the court interpreted the plaintiff's complaint in a liberal manner. The court stated that the racial comments made by the doctor-defendant may be sufficient to prove intentional discrimination.[138] Moreover, the court declared that "[w]hile '[c]onclusory allegations of generalized racial bias do not establish discriminatory intent,'

> to any person any of the accommodations, advantages, facilities or privileges thereof . . . on account of race, creed, color, national origin . . ."

[129] *Id*. at 7. The claims that were dismissed were 42 U.S.C. §§ 1982, 1983, 1985, and 1988.

[130] *Okpor v. Kennedy Health System*, 2010 WL 3522784, at *7. The court stated that amendment of the complaint under 42 U.S.C. §§ 1982, 1983 and 1985 would be restricted to the allegations against the two doctor defendants, not the Kennedy Health System-defendant, because it is not considered "a 'person' who could be subject to liability under the statutes." *Id*. As to section 1988 of the statute, the court declined to grant plaintiff leave to amend his complaint because he lacked the right to redress under the statute. *Id*.

[131] *Id*. at *7.

[132] *Id*. at *3.

[133] *Id*.

[134] *Id*. (citing *Brown v. Philip Morris Inc.*, 250 F.3d 789, 797 (3d Cir. 2001)).

[135] *Okpor v. Kennedy Health System*, 2010 WL 3522784, at *3 (citing *Ocasio v. Lehigh Valley Family Health Ctr.*, 368 F. Supp. 2d 370, 377 (E. D. Pa. 2003)).

[136] *Okpor v. Kennedy Health System*, 2010 WL 3522784, at *3 (citing *Croker v. Boeing Co.*, 662 F.2d 975, 988 (3d Cir. 1991)).

[137] *Okpor v. Kennedy Health System*, 2010 WL 3522784, at *3. *See* N.J.S.A. 10:5-5 (1) which designated "a hospital as a place of public accommodation," which the plaintiff-Okpor argued imposed a legal duty on defendant-Kennedy Hospital not to discriminate against any person requesting medical assistance. *Id*. at *2.

[138] *Id*. at *3.

[plaintiff] Okpor has alleged enough facts to support an allegation of intentional discrimination, which if believed, state a claim for relief."[139]

In addressing the third requirement of a section 1981 claim, the court in *Okpor* focused on discrimination and Kennedy Hospital's and its physicians' contractual obligations concerning persons who sought medical care at the hospital. The court stated that the hospital-defendant, in its capacity as a place of public accommodation, had "an implied contractual agreement to assist emergency room visitors pursuant to N.J.S.A. 10:5-12(f)(1),[140] as well as the duty not to refuse to provide medical treatment to any person on the basis of race. Additionally, a physician who denied treatment to a particular patient may have breached his contractual obligations.[141]

An alleged common law breach of contract was the second, and only other claim filed by the plaintiff, on which the court gave permission to proceed.[142] The court stated that the facts asserted by the plaintiff as the basis for his action for breach of contract, "viewing his complaint liberally, could be established from the facts alleged."[143] In brief, the claims for common law breach of contract and section 1981 race discrimination were both permitted by the court to move forward as requested in plaintiff-Okpor's application to proceed *in forma pauperis* according to 28 U.S.C. § 1915, which mandates proof of indigence.[144]

In a second case illustration, the plaintiff, an African American female, in the case of *Williams v. Kaiser Foundation Health Plan*,[145] alleged that she was subjected to race discrimination while she was at Kaiser Hospital in Oakland, California. Alleging federal and state civil rights violations under 42 U.S.C. § 1981 and the Unruh Civil Rights Act, plaintiff-Williams asked for monetary compensation and injunctive relief in her complaint.[146] Plaintiff asserted further that she was denied medical services due to her race . . . , accused of being a drug addict and called a racial epithet by a doctor."[147] The United States District Court in the *Williams* case stated that the plaintiff's problems apparently began when she received a letter from the Medical Center Committee indicating concern about how she was utilizing her prescription pain medication. The letter recommended that Plaintiff make an appointment with her regular doctor and informed her that she would be receiving information from the Chemical Dependency Program. Due to the contents of this letter, Plaintiff allegedly sustained harm to her reputation, and experienced mental distress and humiliation.[148]

On the day of Plaintiff's follow up appointment at the hospital concerning her migraine headaches and high blood pressure condition, she met with Dr. Kleinsinger, one of the defendants named in the suit. In addition to the doctor telling Plaintiff that he had been advised by Kaiser that

[139] *Id*. at *4 (citing *Jones v. Sch. Dist. Of Phila.*, 19 F. Supp. 2d 414, 421 (E. D. Pa. 1998)).
[140] *Okpor v. Kennedy Health System*, 2010 WL 3522784, at *4.
[141] *Okpor v. Kennedy Health System*, 2010 WL 3522784, at *4.
[142] *Id*. at *6.
[143] *Id*.
[144] *Id*. at *1.
[145] No. C 98-4754JL., 2001 WL 590036 (N. D. Cal. May 23, 2001).
[146] *Id*. at *2.
[147] *Id*. at *1.
[148] *Id*.

Plaintiff was "addicted to drugs,"[149] Plaintiff's testimony also revealed that the doctor declined to treat her stating, " 'I don't treat niggers on drugs . . . .' "[150] In response to this remark, Plaintiff Williams screamed at Dr. Kleinsinger, and Plaintiff testified further that she was told by the doctor "to get out of the exam room and . . . in the process of removing her from the exam table he ripped the sleeve of her shirt and told an employee to call the police. [Afterwards], Plaintiff went home and called the police . . . to charge Dr. Kleinsinger with battery and slander."[151] During the trial, photographs were introduced by Plaintiff revealing a bruise on her arm[152] allegedly from being pulled by the arm and dragged off the examination table by the doctor after refusing to treat Plaintiff for migraine headaches.[153] In court, Plaintiff also adamantly denied using street drugs, and she proved that the use of eye drop medication to control her glaucoma ailment caused redness of the eyes, which she believed may have led the health care professionals to assume that Plaintiff was addicted to drugs.[154]

Finally, the *Williams* court concluded that Plaintiff's racial discrimination complaint lacked a factual or legal basis, and was thereby found to be completely without merit and "dismissed with prejudice,"[155] which had "the same effect as a final adjudication, barring the right to bring or maintain an action later on the same claim or cause."[156] There were several findings of fact that led to the court's order and conclusion of law. The allegations that Dr. Kleinsinger physically abused Ms. Williams by injuring her arm and calling her a racial epithet were not credible claims according to the court. The actions of the doctor, Kaiser Hospital and its employees were found to have been reasonable and in the best interest of Plaintiff.[157] The denial of medical care by the doctor defendant was found to be due to a legitimate concern for Plaintiff's health and welfare, and the availability the next day of her own primary care doctor that could prescribe the appropriate pain medication for her migraine headaches since he was very familiar with Plaintiff's various ailments. Furthermore, since Plaintiff allegedly had a very demanding, unreasonable disposition and admitted in court to calling one of the African American Kaiser Hospital employees a racial epithet, Plaintiff Williams was viewed by the court as the only person in this situation that had behaved in an improper manner.[158] Defendant-Dr. Kleinsinger, on the other hand, not only refuted most of Plaintiff's allegations, but he testified at trial "that he has no animus toward African-Americans, having been active since college in civil rights activities. He has practiced medicine for thirty years, almost the entire time caring for African-Americans as a significant number of his patients."[159] Moreover, some of the other employees from Kaiser Hospital evidently thought well of Dr. Kleinsinger as indicated by their testimonies during the trial that the doctor's demeanor toward patients, as well as staff members, was courteous.[160] Since Plaintiff failed to prove by a preponderance of the evidence that she was deprived of medical

[149] *Id*.
[150] *Id*.
[151] *Id*.
[152] *Id*.
[153] *Id*. at *2.
[154] *Id*. at *3.
[155] *Id*. at *4.
[156] William P. Statsky, West Legal Thesaurus/Dictionary 805 (1985).
[157] *Williams v. Kaiser Foundation Health Plan*, 2001 WL 590036, at *4.
[158] *Id*. at *3.
[159] *Id*.
[160] *Id*.

services based on her race by either Kaiser Hospital or Dr. Kleinsinger, the court could not find a violation of Plaintiff's civil rights.[161] Additionally, due to the absence of any proof that Plaintiff ever filed an administrative claim with a federal or state civil rights agency, the court found that her administrative remedies under the state, Unruh Civil Rights Act had not been exhausted. In fact, the evidence showed that Plaintiff only reported the incident that occurred at Kaiser Hospital to Medicare, who responded by disallowing one-half of the doctor's fee for Plaintiff's office visit on that day.[162]

In a third discrimination case, a federal court, in *National Association For The Advancement Of Colored People v. Wilmington Medical Center*,[163] considered an action brought against a major medical center by five organizations and six individuals representing minorities and disabled persons, most of whom lived in Wilmington, Delaware.[164] The controversy focused on the Wilmington Medical Center's (WMC) decision to relocate the major tertiary care units of its inner-city hospital to a suburban area. As a result of this proposed relocation (Plan Omega), the plaintiffs asserted violations of their rights under Title VI of the Civil Rights Act of 1964[165] and Section 504 of the Rehabilitation Act of 1973[166] by the WMC.[167] The other defendants named in this action included the Secretary of the Federal Department of Health, Education and Welfare (HEW), the Director of the Delaware Bureau of Comprehensive Health Planning (BCHP), and the Chairman of the Health Planning Council, Inc. of New Castle Council, Inc. of New Castle County (HPC).[168] Among other things, the plaintiffs' complaint sought an injunction to stop the commencement of the construction phase of the relocation (Plan Omega) pending the result "of a civil rights 'compliance review' of the proposal by the federal defendant-[HEW]."[169]

In general, the plaintiffs' complaint under Title VI and Section 504 alleged that WMC's proposed relocation of "hospital services to the suburban location . . . [would] cause disparities in the availability and quality of medical care for the urban community[,] a result that . . . would impact disproportionately upon the poor, the elderly, ethnic and racial minorities, and the handicapped."[170] Specifically, the plaintiffs maintained that the remaining components of the hospital would be transformed into a "ghetto" facility since it would be serving primarily African Americans, Puerto Ricans and the groups previously mentioned while the proposed suburban

[161] *Id*.
[162] *Id*. at *4.
[163] 453 F. Supp. 280 (D. Del. 1978), *remanded by* 599 F.2d 1247 (3rd Cir. 1979) to 491 F. Supp. 290 (D. Del. 1980), *aff'd*, *National Association For The Advancement of Colored People v. The Medical Center, Inc.*, 657 F.2d 1322 (3rd Cir. 1981).

The United States Court of Appeals in the 1981 opinion above, held that disparate impact allegedly arising out of the Medical Center-defendant's proposed relocation and reorganization plan may be sufficient to prove discrimination under Title VI of the Civil Rights Act of 1964. However, sufficient evidence was put forward by the Medical Center warranting its plan to relocate and reorganize even in view of the assumption that a prima facie case of discrimination was presented by the plaintiff organizations. The judgment of the district court was affirmed. *Id*. at 1337 & 1338.
[164] 453 F. Supp. 280, 284 (D. Del. 1978).
[165] 42 U.S.C. § 2000d, *cited in* National Association For the Advancement Of Colored People v. Wilmington Medical Center, 453 F. Supp. at 284.
[166] 29 U.S.C. § 794, *cited in* National Association For the Advancement Of Colored People v. Wilmington Medical Center, 453 F. Supp. at 284.
[167] *Id*.
[168] *Id*. at 284-85.
[169] *Id*. at 284.
[170] *Id*.

facility would attract and serve the more affluent, white residents living in suburban New Castle County.[171] Also, it was emphasized by the plaintiffs that relocating particular acute care medical services exclusively to the suburban facility would result in those services not being available to a large number of minority and disabled Wilmington residents and those living in the northern section of New Castle County.[172] This relocation of acute care services to the suburban facility (Stanton Division) would further aggravate "the segregatory effect of a dual hospital system"[173] in that in addition to the attraction of the white, more affluent patients, the staff at Stanton would be essentially composed of board certified specialists while the urban facility (Delaware Division) would be mostly staffed by interns and residents. Consequently, the various services provided in the two divisions would be qualitatively dissimilar.[174]

The Secretary of HEW, BCHP and HPC defendants were alleged to have violated Title VI and Section 504 because they officially approved "a federally assisted hospital relocation project that . . . [would] have the effect of excluding from participation, denying benefits to, and discriminating against persons on the ground of race, color, national origin or handicap."[175] Finally, the court concluded that the WMC was affirmatively obligated pursuant to the contract of assurances to eliminate the probable disparate impact of the proposed relocation (Plan Omega) on minorities in the urban area. Furthermore, the evidence reasonably substantiated the HEW Secretary's decision to authorize the contract of assurances as a sufficient remedy to make sure that Plan Omega conformed to the requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. The assertion that Plan Omega (as modified) would violate the two preceding federal Acts was found by the court not to be supportable; thus, a final judgment was entered for the HEW Secretary and the Wilmington Medical Center defendants.[176]

A fourth action involved allegations made by a White post graduate medical resident in the case of *Hall v. New York Hospital*,[177] who was terminated from New York's Hospital's Ophthalmology Residency Program for unsatisfactory performance after he complained that he observed racial bias by several White physicians towards two Black patients.[178] Several causes of action were alleged in Plaintiff Hall's amended complaint including violations of the following: 42 U.S.C. §§ 1981 and 1985; New York State and City Human Rights Laws; defamation; breach of contract; fraud; and other state claims.[179] Generally, in the *Hall* case, Plaintiff asserted that the reason for his termination from the residency program was that he reported to his superiors that two of his patients were refused prompt medical treatment, which he referred to as "whistle blowing activities."[180] Plaintiff also stated in his complaint that he was opposed to the "illegal and discriminatory treatment of [B]lack patients with respect to the provision of emergency services"[181] by the defendants. Specifically, as to one of the Black patients of which Plaintiff was

[171] *Id*. at 289.
[172] *Id*.
[173] *Id*. at 290-91.
[174] *Id*. at 290 n. 34.
[175] *Id*. at 290.
[176] *Id*. at 330.
[177] No. 00 Civ. 7858 GBD, 2003 WL 22902125 (S.D.N.Y. Dec. 8, 2003), *aff'd*., 117 Fed. Appx. 790 (2004).
[178] *Id*. at *1.
[179] *Id*. at *3.
[180] *Id*. at *1.
[181] *Id*.

asked to perform an emergency eye operation, several White senior physicians purposefully refused to permit the transfer of the patient to another medical facility when it became clear that Defendant-New York Hospital could not provide the necessary surgery. The conduct displayed by the senior physicians contradicted the hospital's own policy and also ignored or disregarded the patient's request to be transferred to another health care facility.[182]

The second incident allegedly involved a Black child patient who required emergency surgery as treatment for a traumatic eye injury. In response to Plaintiff's request for assistance from several White senior physicians to evaluate and treat the Black child, the physicians rejected Plaintiff and allegedly "gave pretextual explanations" for their intentional refusal to come into the hospital to help Plaintiff carry out his assignment.[183] Some of these White senior physicians allegedly " 'asked excessive and medically unnecessary questions, such as what part of New York City the child was from . . . [as well as] the child's race and health insurance.' "[184] No specific claims were made by Plaintiff with respect to either of these incidents concerning the senior physicians having knowledge that the patients were Black or that Plaintiff ever informed anyone of the racial classification of either patient.[185]

The court in *Hall* considered Plaintiff's various allegations concerning the discriminatory manner in which his two Black patients were treated by some of the White senior physicians and pointed out some of the inadequacies of Plaintiff's section 1981 claim.[186] Firstly, as previously stated, the court emphasized Plaintiff's failure to allege "that the senior physicians were actually made aware that the patient[s] in question . . . [were] black."[187] Secondly, the court highlighted the Plaintiff's failure to allege any "facts to support a conclusion that a departure from the standard of care occurred because the patient[s] . . . [were] black. Nor does he allege that the individual defendants responsible for his termination were aware of his patient[s]' race."[188] In sum, the *Hall* court reasoned that although Plaintiff had standing to sue under section 1981 as a White person, his contention that his two Black patients were subjected to a disparate standard of care because of their race, as compared with other patients at the hospital, lacked adequate support. Plaintiff's allegations, therefore, were viewed by the court as completely conclusory and unsupported by facts sufficient to conclude that the New York Hospital-Defendant treated Plaintiff-Hall unfairly, or that the patients in question were treated unfairly because they were Black.[189]

Other courts have also been confronted with actions involving an assortment of allegations of racial or ethnic disparities in the provision of health care. An African American physician in the case of *Taylor v. Flint Osteopathic Hospital, Inc.*,[190] sued a hospital, various hospital officials,

---

[182] *Id*.
[183] *Id*.
[184] *Id*.
[185] *Id*.
[186] *Id*. at 5.
[187] *Id*.
[188] *Id*.
[189] *Id*. According to *Yusef v. Vassar College*, 35 F.3d 709, 713 (2d Cir. 1994), "[i]n order to survive a motion to dismiss, the plaintiff must specifically allege the events claimed to constitute intentional discrimination as well as circumstances giving rise to a plausible inference of racially discriminatory intent." *Hall v. New York Hospital*, 2003 WL 22902125, at *6.
[190] 765 F.2d 146, 1985 WL 13278 (C.A.6 (Mich.) May 29, 1985).

and the Professional Standards Review Organization (PSRO) and some of its officials under various civil rights laws, the Social Security Act, and state law claims. The state actions sought recovery for defamation, invasion of privacy and intentional harm.[191] Plaintiff alleged that he and his African American patients were discriminated against because of their race by the PSRO officials in that many of the services that Plaintiff provided for his patients on Medicaid or Medicare were determined not to be medically essential, and therefore, reimbursements for such services under those programs would not be permitted. Plaintiff further asserted that he and his patients were discriminated against on the basis of race by hospital officials in that various staff privileges were taken from him followed by suspension, which ultimately resulted in his patients being deprived of his medical assistance.[192] The *Taylor* court vacated the United States District Court judgment, and remanded this case for trial to consider the merits of claims under section 1981 of the Civil Rights Act and any surviving pendent (supplementary) actions.[193]

Several African American physicians, dentists and patients brought suit on behalf of themselves and other African American citizens and residents that were similarly situated against two hospitals and their administrators and directors in the case of *Simkins v. Moses H. Cone Memorial Hospital*,[194] alleging race discrimination. Two of the plaintiffs, who were patients, needed medical care, and they wished to be admitted to either the Cone Memorial Hospital (Cone Memorial) or the Wesley Long Community Hospital (Wesley Long) because those facilities were allegedly superior to others in Greensboro and had the most complete medical equipment, which enhanced their ability to provide better health care to their patients. Additionally, not only did the two patients want to be admitted to and treated at either the Cone Memorial or Wesley Long Hospital, they wished to be treated by their personal physicians, who were also African Americans.[195] Both hospitals were nonprofit charitable corporations under North Carolina state law, and they were owned and managed by boards of trustees. African American patients and professionals were totally banned from Wesley Long Hospital. At the Cone Memorial Hospital only a few African American patients were carefully chosen and admitted based on special conditions that did not apply to White patients. No staff privileges were given to African American physicians or dentists at the time this complaint was filed.[196] The United States Court of Appeals agreed with the United States District Court's finding that the plaintiffs' assertions of racial discriminatory acts by the two hospitals were " 'clearly established;' "[197] however, the District Court concluded that the hospitals were private persons and corporations, who were not instrumentalities of state or federal government and therefore were not subject to the restraints of either the Fifth or Fourteenth Amendment to the United States Constitution.[198]

---

[191] *Id*. at *1.
[192] *Id*.
[193] *Id*. at *2.
[194] 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964).
[195] *Id*. at 962.
[196] *Id*. Subsequent to the United States District Court issuing an order dismissing the *Simkins* case, the Cone Memorial Hospital informed the plaintiffs and the public that it would consider staff applications from African Americans; however, the admission policy for African American patients would remain the same. *Simkins*, 323 F.2d at 962 n. 5.
[197] *Id*. at 962. *See also Simkins v. Moses H. Cone Memorial Hospital*, 211 F. Supp. 628, 634 (M.D.N.C. 1962) (United States District Court opinion).
[198] *Id*. at 641.

The Court of Appeals reversed the District Court's judgment and remanded the case declaring that the portion of the Hill-Burton Act (Hospital Survey and Construction Act), as amended 42 U.S.C.A. § 291e (f) and relevant regulations that tolerated "separate-but-equal" facilities were invalid.[199] Consequently, the Court of Appeals' judgment constituted a rejection of the hospital defendants' applications for federal funds for building projects that openly stated, as allowed by the Hill-Burton Act and regulation, that " 'certain persons in the area will be denied admission to the proposed facilities as patients because of race, creed or color.' "[200] Although these grant applications had been approved by the North Carolina Medical Care Commission and the United States Surgeon General pursuant to his statutory authority, the Court of Appeals held that the relevant parts of the federal statute and regulation in question in *Simkins* were unconstitutional because they violated the Due Process Clause (equal protection guarantee) of the Fifth Amendment[201] and the Equal Protection Clause of the Fourteenth Amendment.[202]

The following cases are additional examples of controversies involving allegations of disparities in the provision of health care based on race:

- In the case of *Parks v. O'Young*,[203] the claimant, a recovery room nurse asserted that she submitted to her supervisor an occurrence report describing an incident she observed involving the mistreatment of a Black minor patient by a physician defendant at St. Bernard Hospital, who was also a defendant.[204] In the nurse claimant's tortious interference with contract action against the physician in question, the claimant stated that she observed the physician defendant "violently shake the neck of a nine-year-old [Black] patient; verbally abuse that patient by making racially charged remarks about that patient; and mistreat the patient by inappropriately pulling on the traction apparatus to which the patient's leg was connected."[205] Additionally, in connection with this cause of action, the claimant described the physician defendant's interference and termination of claimant's employment with the Hospital defendant as an intentional and malicious act in the form of a false accusation. The accusatory statement made by the physician was that the nurse claimant disclosed confidential information concerning the mistreatment incident to the child patient's family.[206] In affirming the trial court's judgment for the physician defendant, the Illinois Appellate Court emphasized the lack of proof establishing that the physician made accusatory statements about the claimant or that he caused the termination of claimant's employment with the Hospital defendant.[207]

[199] *Simkins v. Moses H. Cone Memorial Hospital*, 323 F.2d at 969. The specific "separate-but-equal" language of the Hill-Burton Act that was declared invalid by the United States Court of Appeals provided: "but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group. *Id*. (citing 42 U.S.C.A. § 291e (f)).
[200] *Simkins v. Moses H. Cone Memorial Hospital*, 323 F.2d at 962.
[201] *Id*. at 969.
[202] *Id*.
[203] 682 N.E.2d 466 (Ill. Ct. App. 1997).
[204] *Id*. at 469.
[205] *Id*.
[206] *Id*.
[207] *Id*. at 474.

- In the case of *Wilson v. Seiter*,[208] a Black male inmate asserted mistreatment during his incarceration at Hocking Correctional Facility (HCF). Plaintiff cited violations under 42 U.S.C. § 1983, due process, and equal protection related to harassment, discipline and denial of a transfer.[209] Allegedly, "[W]hite prison guards and medical personnel at HCF subjected [plaintiff] . . . to extensive harassment including intentional denial of necessary medical care and unwarranted shakedown searches because of his race."[210] The denial of Plaintiff's request for a transfer to another prison was also allegedly motivated by racial discrimination. The court affirmed the lower court's order to grant summary judgment on the section 1983 action and the qualified immunity as to the due process claim. The equal protection action failed due to insufficient evidence.[211]

V. RACIAL AND ETHNIC DISPARITIES RELATED TO COVID-19

The Center for Disease Control and Prevention (CDC), our national public health agency under the Department of Health and Human Services, conducted two studies in which it investigated the "trends in racial and ethnic disparities in hospitalizations and emergency room visits associated with COVID-19 in 2020."[212] The studies were released a short time after the CDC Director, Rochelle Walensky, declared "racism a serious public health threat."[213] Walensky also stated that "[t]he COVID-19 pandemic and its disproportional impact on communities of color is . . . [a] glaring example of health inequities that threaten the health of our nation."[214] The findings of two CDC studies (subsequent to CDC's assessment of administrative discharge information from March to December of 2020) were as follows:

- In the first study, the CDC found that Hispanic and Latino persons living in all four census regions of the United States represented the greatest proportion of patients hospitalized with COVID-19 during the 2020 March to December period.[215]
- Between the months of May and July of 2020, racial and ethnic disparities were most noticeable, but decreased during the pandemic as non-Hispanic White persons began to be hospitalized in greater numbers. However, as of December of 2020, disparities continued across the United States mostly among Hispanic patients living in the Western part of the country.[216]
- Two factors were discovered by the researchers as reasons for the disproportionate hospitalizations of minorities: "a higher risk of exposure to the virus and a higher risk for severe disease."[217] The demographic patterns that the researchers observed

[208] 893 F.2d 1336, 1990 WL 1125 (6th Cir. 1990).
[209] *Id*. at *1.
[210] *Id*.
[211] *Id*.
[212] Rachel Treisman, *Studies Confirm Racial, Ethnic Disparities in COVID-19 Hospitalizations and Visits*, NPR (April 12, 2021), https://www.npr.org/sections/coronavirus-live-updates/2021/04/12/986513859/studies-confirm-racial-ethnic-disparities-in-covid-19-hospitalizations-and-visit.
[213] *Id*.
[214] *Id*.
[215] *Id*.
[216] *Id*.
[217] *Id*.

revealed "differences in exposure risk associated with occupational and housing conditions, as well as socioeconomic status."[218]

- In the second study, the CDC found much the same disparities between racial and ethnic groups involving COVID-19 related visits to the emergency room between October and December of 2020 in thirteen states. It was reported that "[d]uring that period, Hispanic and American Indians or Alaska Native people were 1.7 times more likely to seek care than [W]hite people, and Black individuals 1.4 times more likely."[219]
- "[L]ong-standing and systemic inequities" such as "limited access to quality health care and disproportionate representation in 'essential' jobs with less flexibility to take leave or work remotely," adversely impact the health of "Hispanic and American Indian or Alaska Native people" and Blacks. The researchers noted that these health inequities are mainly driven by racism rather than an individual's race or ethnicity. The risk of exposure to COVID-19 and delayed medical assistance are increased by such inequities, which in turn increase the risks for severe disease results and the necessity for one to seek emergency medical care.[220]

There are various ways the CDC has said it is currently and it will in the future address the inequities related to COVID-19 and health care in general. These remedies include the following:

- The "findings could be used to prioritize vaccines and other resources for disproportionately affected communities in an effort to reduce the need for emergency care."[221]
- "[A]ddress health equity as a core element in all of our public health efforts . . . ."[222]
- The CDC Director "Walensky has directed the agency's departments to develop interventions and measure health outcomes" during 2021.[223]
- The CDC "provided $3 billion to support efforts to expand equity and access to vaccines, in addition to $2.25 billion previously allocated for COVID-19 testing in high-risk and underserved communities."[224]
- A Racism and Health web portal has been launched by the CDC "to promote education and dialogue on the subject."[225]
- One of CDC's focal points is "making sure the distribution of COVID-19 vaccines across the U.S. reaches communities that have been hit the hardest."[226]

---

[218] *Id*.
[219] Treisman, *Studies Confirm Racial, Ethnic Disparities in COVID-19 Hospitalizations and Visits*, NPR (April 12, 2021), https://www.npr.org/sections/coronavirus-live-updates/2021/04/12/986513859/studies-confirm-racial-ethnic-disparities-in-covid-19-hospitalizations-and-visit.
[220] *Id*.
[221] *Id*.
[222] *Id*.
[223] *Id*.
[224] *Id*.
[225] Treisman, *Studies Confirm Racial Ethnic Disparities in COVID-19 Hospitalizations and Visits*, NPR (April 12, 2021).
[226] *Id*.

Another organization that has taken a stand in the fight against disparities in health care is the American Association of Retired Persons (AARP). It is a powerful organization for people that are age fifty and older in the United States. AARP provides many services which include member benefits, lobbying on behalf of its members, and marketing services.[227] Ways in which AARP is addressing pandemic related disparities include:

- AARP is "working to lower the cost of prescription drugs. Because people of color experience higher rates of chronic illness, such as high blood pressure, diabetes and heart disease, they are more reliant on those drugs and are hit harder by their high costs."[228]
- AARP is "working to help people adopt healthy lifestyles to reduce instances of chronic conditions—such as obesity, diabetes, heart disease and asthma—that often are a result of a lack of exercise, poor nutrition, limited access to health care and environmental factors."[229]
- For decades AARP has "worked . . . to improve conditions in America's long-term care facilities, where Blacks and Hispanics [have] suffered disproportionately during the pandemic.[230]

VI. CONCLUSION

This review of systemic racism and minority disparities in health care clearly illustrates that a serious problem has existed throughout this country's history regarding the attitudes, conduct, and provision of health care generally by our medical professionals and institutions. The adverse impact of racial discrimination on the physical and mental health of African Americans, for example, has been studied and is well documented by various scholars which can be traced back to the institution of slavery as described in this article. As stated previously, many years before African Americans experience illness they have been exposed to "stress and toxins" that adversely affect their "ability to live safely and freely." Research has shown that once African Americans, the poor and other persons of color become ill, they often report a difference in the medical care they receive. Thus, more improvement in the provision of health care is needed regarding these significant groups, which in turn may improve the feeling of distrust of medical professionals expressed by many persons. Although we have seen overall improvement in the lives of African Americans, poor health persists as is apparent in a 2020 CDC study on racial and ethnic disparities related to COVID-19. As revealed in the CDC study, the health of African Americans, Hispanic and American Indian or Alaska Native people has been impacted by "long standing and systemic inequities" due to less access to quality health care and "disproportionate representation in 'essential jobs' " that provide little or no flexibility to work from home or possibly take a leave.[231]

---

[227] Adam Hayes, *AARP*, Investopedia (Updated Nov. 25, 2020), https://www.investopedia.com/terms/a/aarp.asp.
[228] JoAnn Jenkins, *Fighting Disparities in Health Care*, AARP Bulletin, 62 AARP Bulletin 42 (June 2021).
[229] *Id*.
[230] *Id*.
[231] *See* Treisman, *Studies Confirm Racial Ethnic Disparities in COVID-19 Hospitalizations and Visits*, NPR (April 12, 2021).