The Disparate Impact of the Coronavirus Pandemic on People of Color and the Efficacy of Race-Based Health Policies

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The coronavirus pandemic was, for all intents and purposes, a national emergency that highlighted the lack of quality healthcare for people of color and the overall lack of trust that communities of color, in general, have for medical professionals. In particular, Blacks, Latino/x, and Native Americans experienced higher hospitalization and death rates than White people. Part of the reason is because Black and Latino/x communities were overrepresented in essential service jobs during the pandemic, and these jobs did not allow for the ability to work from home. Other reasons stem from a lack of trust due to a history of discrimination in the medical field, lack of health insurance, and the quality of healthcare facilities in areas with diverse populations.

Given the disproportionate impact of COVID-19 on people of color, states like Utah, Minnesota, and New York, implemented race-based health policies to decrease the hospitalization and mortality rate among people of color, effectively creating affirmative action programs for healthcare treatment. Yet, these policies would likely not survive the Supreme Court's strict scrutiny test. Additionally, given the historical relationship between the medical field and communities of color, using race may not be an effective path to achieve better health outcomes for people of color. This Note will present solutions to improve healthcare outcomes for people of color, incorporating the lessons learned from the COVID-19 pandemic.

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Introduction 638
I. The Historical Relationship Between People of Color and the Medical Profession 639
A. Lack of Healthcare Access 639
B. Mistrust of Medical Professionals 641
C. Bias, Stereotypes, and Differential Treatment by Medical Professionals 645
II. The Impact of the Coronavirus on People of Color 646
III. Healthcare Access and the Supreme Court's Strict Scrutiny Test 649
A. The Strict Scrutiny Test 649
B. Race-Based Policies During the COVID-19 Pandemic 650
C. The Efficacy of Race-Based Health Policies 655
IV. Legal and Policy Considerations to Address Racial Health Disparities 657
A. Developing a Diversity Pipeline into the Medical Profession 658
B. Increasing Healthcare Accessibility 660
C. Implementing Empathy, Cultural Competency, and Implicit Bias Training 661
Conclusion 663

INTRODUCTION

The rise of the Coronavirus pandemic ("the pandemic") exposed the health disparities that exist in communities of color. Some of the underlying reasons for the disproportionate impact of COVID-19 on racial minorities were the overrepresentation in essential jobs that did not allow for the option to work from home, and the need to get a paycheck despite the risk of contracting the virus.[1] Moreover, racial minority groups are less likely to have healthcare[2] and take vaccines in comparison to their White counterparts.[3] The COVID-19 mortality rates among the Latino/x, Native American, and Black populations were all higher than the death rate for White people.[4] This Note will discuss whether there should be explicitly race-based policies to address health disparities, and whether race-based policies can survive the Supreme Court's strict scrutiny test. To tackle this question, this Note will first address the historical relationship between the medical field and healthcare professionals to people of color by assessing the historical relationship between people of color and the medical profession in the United States.

Next, this Note will consider the impact of COVID-19 on people of color and analyze the reasons why racial minority groups were harder hit by the virus. This

1. Ruqaiijah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, 7 J. L. & THE BIOSCIENCES 1, 4 (2020).

2. Heeju Sohn, *Racial and Ethnic Disparities in Health Insurance Coverage: Dynamics of Gaining and Losing Coverage Over the Life-Course*, 36 POPULATION RSCH. POL'Y REV. 181, 181 (2016).

3. Mathieu Rees, *Racism in Healthcare: What You Need to Know*, MED. NEWS TODAY (Oct. 18, 2024), https://www.medicalnewstoday.com/articles/racism-in-healthcare [perma.cc/RV5S-H8VK].

4. Nambi Ndugga, Latoya Hill & Samantha Artiga, *COVID-19 Cases and Deaths by Race/Ethnicity: Current Data and Changes Over Time*, KFF (Nov. 17, 2022), https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-cases-and-deaths-by-race-ethnicity-current-data-and-changes-over-time/ [perma.cc/9HWZ-SD9X] (discussing mortality rates among different populations during COVID-19).

Note will also analyze the efficacy of state-adopted, race-based policies to address the spread of COVID-19. This Note will address the policies implemented by New York City, Utah, and Minnesota in distributing COVID-19 treatments based on race. This Note will then apply the Supreme Court's strict scrutiny test to these race-based COVID-19 policies. Lastly, this Note will explore legal and policy considerations to improve the health disparities among people of color. This Note seeks to present a historical point of view to help explain some of the disparities faced by people of color during the pandemic. The historical perspective and insights to the pandemic are meant to pinpoint some of the opportunities to make meaningful change so people of color have greater access to quality healthcare.

This Note concludes by arguing alternatives to using race-based health policies because using these policies would likely fail the Supreme Court's strict scrutiny test. But also using race-based health policies may not actually help increase quality healthcare for people of color. Rather, this Note will argue alternatives to race-based health policies to achieve greater health outcomes for people of color.

I. THE HISTORICAL RELATIONSHIP BETWEEN PEOPLE OF COLOR AND THE MEDICAL PROFESSION

Until the passage of the Civil Rights Act of 1964 (CRA), hospitals were segregated.[5] The American Medical Association barred Black doctors from membership and medical schools barred Black students from enrollment until the CRA banned that discrimination.[6] Today, a majority of physicians are White.[7] The lack of diversity in the medical field can partly be explained by the history of exclusion people of color experienced when interacting with medical professionals. Additionally, other factors can help explain the health disparity that exists today in communities of color.

A. Lack of Healthcare Access

The medical profession's lack of equipment, professionals, and facilities can help explain some of the health disparities that exist in delivering quality of care to people of color. People of color are more likely to work in jobs without health coverage,[8] less likely to see doctors regularly compared to their White counterparts,[9] and face stereotypes from medical professionals.[10] In fact, researchers cite low-income jobs with no health benefits as the primary cause for high uninsurance rates among Black people.[11] Additionally, there is a lack of health insurance at jobs where Latino/x people work.[12] Language barriers and immigration rules also prevent

5. Ji Seon Song, *Cops in Scrubs*, 48 FLA. STATE UNIV. L. REV. 862, 870 (2021).

6. *Id.*

7. Victoria Bailey, *AAMC: Gender and Racial Diversity on the Rise in US Physician Workforce*, TECHTARGET, INC. (Jan. 17, 2023), https://revcycleintelligence.com/news/aamc-gender-and-racial-diversity-on-the-rise-in-us-physician-workforce [web.archive.org/web/20230117172925/https://revcycleintelligence.com/news/aamc-gender-and-racial-diversity-on-the-rise-in-us-physician-workforce].

8. Sohn, *supra* note 2, at 183.

9. Robert J. Blendon, Linda H. Aiken, Howard E. Freeman & Christopher R. Corey, *Access to Medical Care for Black and White Americans: A Matter of Continuing Concern*, 280 JAMA 278, 279 (1989).

10. Michele Goodwin & Erwin Chemerinsky, *The Trump Administration: Immigration, Racism, and COVID-19*, 169 U. PA. L. REV. 313, 331 (2021).

11. Sohn, *supra* note 2, at 183.

12. *Id.*

undocumented and recent immigrants from enrolling in public health plans, which impacts their health coverage.[13] In Asian populations low enrollment in public insurance and jobs without health benefits contributed to uninsurance rates.[14] Prior to the Affordable Care Act, Blacks, Latino/x, and Asians experienced less health coverage.[15] Latino/x people were the highest uninsured of any group.[16] The Black and Latino/x populations also experience greater insurance loss and slower insurance gain.[17] Private health insurance coverage is tied to employment and marriage, and rates of unemployment are higher among Black men and women than their White counterparts.[18] Job loss is also more common among minority groups.[19] Additionally, Black and Latino/x people are less likely to marry than non-Hispanic Whites.[20] Blacks and Latino/x who do marry are more likely to get a divorce and less likely to remarry than non-Hispanic Whites.[21] Ralph Richard Banks, a professor at Stanford Law School, attributed a lack of financial stability among Blacks partly to the low rates of marriage.[22] A 1986 study of White and Black health disparities found that Blacks were more likely than Whites to live in one-adult households.[23]

On average, Whites are expected to live less than eight years without insurance before reaching age sixty-five, for Blacks it is twelve years, for Asian Americans over ten years, and for Latino/x almost twenty-two years.[24] This number for the Latino/x community is startling. A myriad of factors could help explain this lack of coverage such as citizenship status, fear of seeking medical care, or jobs that do not cover medical insurance. This lack of coverage is cause for concern, which helps speak to the next section discussing the disparate impact of COVID-19 on the Latino/x community.

Additionally, finding health coverage is not always easy. A recent survey by the California Health Care Foundation (CHCF) found that Californians with higher incomes are more likely to say it was "easy" or "very easy" to find a healthcare provider who took their insurance compared to low-income people.[25] Another study found that one in eleven Black people report not receiving health care for economic reasons compared to one in twenty Whites.[26] Blacks were also more likely than Whites to prefer a different healthcare provider than the one they saw for their

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13. *Id.*
14. *Id.*
15. *Id.* at 182–83.
16. *Id.* at 183.
17. *Id.* at 184–85.
18. *Id.* at 185.
19. *Id.* (citing BUREAU OF LAB. STATS., LABOR FORCE CHARACTERISTICS BY RACE AND ETHNICITY, 2013 (2014)).
20. *Id.*; *see also* Melissa Murray, *Black Marriage, White People, Red Herrings*, 111 MICH. L. REV. 977, 977–79 (2013) ("In 2007, only 33 percent of black women and 44 percent of black men were married . . . . Today, nearly 70 percent of black women and more than 50 percent of black men are unmarried.") (citing RICHARD FRY & D'VERA COHN, PEW RSCH. CTR., WOMEN, MEN AND THE NEW ECONOMICS OF MARRIAGE 22 (2010)).
21. Sohn, *supra* note 2, at 185.
22. Murray, *supra* note 20, at 981.
23. Blendon et al., *supra* note 9, at 280.
24. Sohn, *supra* note 2, at 190–91.
25. LUCY RABINOWITZ BAILEY, REBECCA CATTERSON, EMILY ALVAREZ & SAGEETHA NOBLE, THE 2023 CHCF CALIFORNIA HEALTH POLICY SURVEY 26 (2023).
26. Blendon et al., *supra* note 9, at 280.

previous visit.[27] Moreover, minority communities tend to have less physicians available.[28] For instance, Black and Hispanic/Latino/x serving hospitals tend to have less hospital buildings and equipment.[29] Thus, not only are people of color, particularly from low-income communities, in jobs without healthcare coverage, there is also a gap in the proximity of quality health care facilities in their neighborhoods. These reasons help explain why the COVID-19 pandemic had a disproportionate impact on people of color.

B. Mistrust of Medical Professionals

Furthermore, although a lack of affordable healthcare helps to explain some health disparities faced by people of color, there are also historical reasons to help provide an explanation. Historically, the U.S. medical profession has created distrust among communities of color, notably through forced sterilization and the forty-year long Tuskegee study. Beginning in the 1950s, sterilization was described as a public health strategy.[30] As early as 1920, eugenicists stereotyped Mexican families for having too many children.[31] In fact in 1927, the Supreme Court ruled in *Buck v. Bell* that forced sterilization did not violate the Constitution.[32] From 1921 to 1930 at Norwalk State Hospital in Southern California, Mexicans were 7.8% of admissions but were sterilized at rates of 11% for women and 13% for men.[33] African Americans were a little over 1% of California's population, but accounted for 4% of total sterilizations.[34] One of the most well-known cases of sterilization abuse was the Relf sisters who were sterilized without consent in 1973 in Alabama.[35] Their case culminated in a lawsuit, *Relf v Weinberger*, where the federal district court Judge Gerhard Gesell wrote that "an indefinite number of poor people have been improperly coerced" into sterilization.[36] Judge Gesell estimated that 100,000 to 150,000 women were sterilized under federally-funded family planning programs.[37]

Throughout the 1960s and 70s at the Los Angeles County-USC Medical Center (USC Medical Center), Mexican women, in particular, did not give informed consent when doctors performed "elective hysterectomies," "tubal ligations," and "post-delivery tubal ligations."[38] In *Madrigal v Quilligan*, female plaintiffs claimed they were coerced into signing consent forms "hours or minutes before or after labor," were ill-informed about the irreversibility of the procedure, or had not given any consent at all.[39] A key witness in the case claimed that Mexican women were

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27. *Id.*
28. *Id.*
29. Gracie Himmelstein & Kathryn E. W. Himmelstein, *Inequality Set in Concrete: Physical Resources Available for Care at Hospitals Serving People of Color and Other U.S. Hospitals*, 50(4) INT'L J. HEALTH SERVS. 363, 365 (2020).
30. Alexandra Minn Stern, *Sterilized in the Name of Public Health*, 95 AM. J. PUB. HEALTH 1128, 1130 (2005).
31. *Id.* at 1135.
32. Buck v. Bell, 274 U.S. 200, 207–08 (1927).
33. Stern, *supra* note 30, at 1131.
34. *Id.*
35. *Id.* at 1133.
36. *Id.* at 1134.
37. *Id.*
38. *Id.*
39. *Id.*

targeted because, as one of the doctor's said, "poor minority women . . . were having too many babies."[40]

Furthermore, from 1932 through 1972, the U.S. Public Health Service launched a longitudinal study of 399[41] African American men with untreated syphilis in Alabama.[42] Officials told the men that they were receiving free healthcare from the government, but the aim was to study the effects of syphilis.[43] Throughout the study, the government did not provide the men with medical treatment for syphilis, even after penicillin became available.[44] This study was called the Tuskegee Syphilis Study, which has had a long-lasting impact on the perception of medical professionals in the Black community.[45] In African American folklore, there was a fear of night doctors that would steal away Black people in the night to perform experiments.[46] Although this was just storytelling, the fear of relying on medical professionals was real.[47] Another example of this fear appeared in the book of *The Immortal Life of Henrietta Lacks*, where the author wrote about white plantation slave owners using night doctors to discourage Black people from escaping or meeting.[48] The story of Henrietta Lacks also reinforces the idea that doctors experiment on Black people. Lacks was a Black woman who entered John Hopkins Hospital because of cervical cancer in 1951.[49] Her cells were used to further biomedical research, which led to meaningful scientific discoveries..[50] However, she never gave consent for her cells to be used for research.[51]

The fear of medical professionals abusing their power to experiment on Black people is not a historical fear. A 1990 survey, conducted by the Southern Christian Leadership Conference, found that 35% of the 1,056 Black church members surveyed believed that AIDS was a form of genocide.[52] For example, a 1990 *Essence Magazine* article titled "AIDS: Is it Genocide?"[53] speaks to the fear and distrust of doctors in the Black community. During the 1989 measles epidemic in Los Angeles (LA), the Centers for Disease Control and Prevention (CDC), along with Kaiser Permanente and the LA County Health Department, began an experiment on a vaccine for children.[54] By 1991, approximately 900 infants, mostly Black and Latino/x, had received the vaccine, but the parents were not informed that the vaccine was not licensed yet in the United States.[55]

40. *Id.* at 1135.

41. Vanessa Northington Gamble, *Under the Shadow of Tuskegee: African Americans and Health Care* 87 AM. J. PUB. HEALTH 1773, 1773 (1997).

42. RALPH RICHARD BANKS, KIM FORDE-MAZRUI, GUY-URIEL E. CHARLES & CRISTINA M. RODRIGUEZ, RACIAL JUSTICE AND LAW: CASES AND MATERIALS 100 (Robert C. Clark et al. eds., 2016).

43. *Id.*

44. *Id.*

45. Gamble, *supra* note 41.

46. *Id.* at 1774.

47. *Id.*

48. REBECCA SKLOOT, THE IMMORTAL LIFE OF HENRIETTA LACKS 166 (2010).

49. *Id.* at 28.

50. *Id.* at 312.

51. *Id.* at 33.

52. Gamble, *supra* note 41, at 1775.

53. *Id.*

54. *Id.* at 1776.

55. *Id.* at 1776–77

A more recent example occurred in 2021, when during the COVID-19 pandemic an Arkansas jail offered incarcerated men ivermectin, a drug to treat COVID-19; however, the Food and Drug Administration (FDA) had not approved the drug to treat COVID-19.[56] The drug ivermectin can be toxic for humans, causing "vomiting, coma, seizures, and even death."[57] Nurses at the jail told the men they were receiving vitamins, not ivermectin.[58] The doctor at the jail, Rob Karas, claimed that the incarcerated men agreed to take the drug voluntarily.[59] Yet, these men were deceived into taking a drug that was not FDA approved for treating COVID-19, nor did they give their informed consent to be given the drug. One man stated that "[i]t was not consensual. They used us as an experiment, like we're livestock."[60] This incident is an eerie reminder of the past Tuskegee Syphilis Study and forced sterilizations where medical professionals operated on the bodies of people of color without their consent. Another impacted man said, "I'm scared. If you were so willing to put something in my pills . . . you could do the same thing and be deceptive and put it in my juice, my food. . . . I can't trust any of the medical staff. I can't trust any of the guards."[61]

Following the Tuskegee Study, Congress passed the National Research Act in 1974 to set ethical standards for government research practices.[62] The Act created the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, which set ethical guidelines such as "informed consent" for people participating in research experiments by the government.[63] This Commission published the Belmont Report, which warned of using incarcerated people for experimentation and the importance of getting uncoerced, voluntary consent.[64] Congress also charged the U.S. Department of Health and Human Services with developing guidelines for any federal agency using people as research subjects.[65] However, these regulations fall short of protecting all people like the men in the Arkansas jail. Greater protections for people, especially incarcerated individuals who already lack freedom, should be implemented to protect against future occurrences of uninformed consent. The Arkansas State Medical Board investigated Rob Karas (the jail doctor) after he was sued by the men who took ivermectin, and he claimed the men signed a "blanket consent form when they [were] booked or when they [were] first given medication."[66] After further

56. Lydia Crafts, *Ivermectin Experiments in Arkansas Jail Recall Long History of Medical Abuse*, WASH. POST (Sept. 15, 2021), https://www.washingtonpost.com/outlook/2021/09/15/ivermectin-experiments-an-arkansas-jail-recall-long-history-medical-abuse/ [perma.cc/9ZRE-XBPU].

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.*

61. *Id.*

62. *The U.S. Public Health Service Untreated Syphilis Study at Tuskegee*, U.S. CTRS. FOR DISEASE CONTROL AND PREVENTION (Nov. 15, 2023), https://www.cdc.gov/tuskegee/about/effects-research.html?CDC_A Aref_Val=https://www.cdc.gov/tuskegee/after.htm [perma.cc/9444-DJ3C].

63. NAT'L COMM'N FOR THE PROT. OF HUM. SUBJECTS OF BIOMEDICAL AND BEHAV. RSCH., DEP'T OF HEALTH, EDUC. & WELFARE, THE BELMONT REPORT (1979).

64. *Id.*

65. U.S. DEP'T OF HEALTH AND HUM. SERVS., SUBPART A. BASIC HHS POLICY FOR PROTECTION OF HUMAN RESEARCH SUBJECTS (2018).

66. Daniel Wu, *Inmates Given Ivermectin in Jail Will Each Get $2,000 After Settlement*, WASH. POST (Oct. 10, 2023), https://www.washingtonpost.com/nation/2023/10/10/arkansas-jail-ivermectin-covid-settlement/ [perma.cc/H5BH-LRXG].

investigation into the consent of these men, the Arkansas Medical Board ultimately voted to take no action again Karas.[67]

Furthermore, the fact that medical professionals must report certain injuries to law enforcement could also explain a lack of trust.[68] In 1996, Congress passed the Health Information Portability and Accountability Act (HIPAA), which provided privacy protections for patient medical information.[69] In 2002 Congress added a Privacy Rule to HIPPA, which allows, but does not require, medical professionals to disclose information to law enforcement for public safety purposes.[70] Most states require reporting of some injuries, such as gun wounds.[71] Medical professionals have provided information to law enforcement about potential criminal activity.[72] In fact, a child's injuries are nine times more likely to be reported when the child is Black rather than White.[73] So, questioning by doctors about how an injury has occurred could provoke fear for seeking medical treatment.

General fear of medical professionals is certainly not a new phenomenon but stems from a long history of mistreatment of people of color by medical professionals. The real fear of people of color being experimented on by doctors is justified through history. Medical instances from the past, such as the Tuskegee experiment, Henrietta Lacks, and forced sterilization demonstrate that doctors have degraded the bodies of racial minorities for experimentation. The lack of consent given by people of color in these experiments also speaks to a general disrespect of medical professionals to the dignity of people of color. This history can help explain the negative experiences people of color continue to face in modern times and the fear that people may have to interact with medical professionals. This history helps explain a fear that people of color may have to trust that medical professionals will deliver quality care. A 2021 study showed that everyday racism and racism in the healthcare industry is more likely to be reported by Black people; the study specifically focuses on African Americans.[74] Racism was shown to partly impact a Black man's utilization of health services,[75] and may help explain, but certainly not fully, why Black men are less likely to receive medical treatment compared to other groups of people.[76] Early medical intervention like screenings and treatments for diseases such as cardiovascular disease, cancer, and diabetes are important to avoid future health problems.[77] So, building trust between medical professionals and diverse communities is an important step to improving health outcomes.

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67. *Id.*
68. Song, *supra* note 5, at 873.
69. *Id.* at 877.
70. *Id.* at 878.
71. *Id.* at 881.
72. *Id.* at 875.
73. *Id.*
74. Wizdom Powell, Jennifer Richmond, Dinushika Mohottige, Irene Yen, Allison Joslyn & Giselle Corbie-Smith, *Medical Mistrust, Racism, and Delays in Preventive Health Screening Among African-American Men*, 45 BEHAV. MED. 102, 103 (2019).
75. *Id.* at 102–03.
76. *See id.* at 102.
77. *See id.*

C. Bias, Stereotypes, and Differential Treatment by Medical Professionals

In general, negative experiences with medical professionals can also influence a person's attitude towards the medical field. In a 1986 study, Blacks were more likely than Whites to report that their physician did not inquire about their pain and did not give enough information about their medical condition.[78] In a more recent study published in 2023, Black and Latino/x Californians were more likely to report a negative experience with a healthcare provider compared to their White and Asian counterparts.[79] Stereotypes about people of color have also played a role in the medical field. A 1993 LA Times article highlighted attitudes towards minorities by students at the USC Medical Center.[80] One student said, "I feel like I'm on Mars," given that 90% of patients at the USC Medical Center were minorities.[81] Comments were made by students such as two White women rushing through examinations with "scary looking" Black men, or another student expressing frustration with the number of babies by Latinas on welfare.[82] Half of the students felt unprepared to face cultural barriers.[83]

Another concern is the quality of care based on ideas that Black people can tolerate more pain than other races. Research has shown that, relative to White people, Black patients are less likely to be given pain medications and, if given pain medications, Black patients receive lower quantities.[84] In one study, doctors were more likely to underestimate the pain of Black people.[85] This same result occurred in another study of one million children, which showed that Black children were less likely to receive any pain medication for moderate pain and were less likely to receive opioids for severe pain compared to White children.[86] The belief that Black people can tolerate more pain has also been shown to be held by medical students.[87]

Moreover, people of color may also fear being treated differently by medical professionals because of their race. For instance, Black women are three times more likely to die from pregnancy related causes than White women.[88] Some of the

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78. Blendon et al., *supra* note 9, at 280.

79. BAILEY ET AL., *supra* note 25, at 3.

80. Sonia Nazario, *Treating Doctors for Prejudice: Medical Schools Are Trying to Sensitize Students to 'Bedside Bias.' Studies Show That the Effects on Women and Minorities Can Mean Ruder Treatment and Less Access to Better Care*, L.A. TIMES (Dec. 20, 1993, 12:00 AM), https://www.latimes.com/archives/la-xpm-1993-12-20-mn-3935-story.html [perma.cc/RDJ6-DRT8].

81. *Id.*

82. *Id.*

83. *Id.*

84. Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PNAS 4296, 4296 (2016).

85. *Id.*

86. *Id.*

87. *Id.*

88. Martha Hostetter & Sarah Klein, *Understanding and Ameliorating Medical Mistrust Among Black Americans*, COMMONWEALTH FUND (Jan. 14, 2021), https://www.commonwealthfund.org/publications/newsletter-article/2021/jan/medical-mistrust-among-black-americans; *see also* Munira Z. Gunja, Shanoor Seervai, Laurie C. Zephyrin & Reginald D. Williams II, *Health and Health Care for Women of Reproductive Age: How the United States Compares With Other High-Income Countries*, COMMONWEALTH FUND (Apr. 5, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/apr/health-and-health-care-women-reproductive-age [web.archive.org/web/20220405140435/https://www.commonwealthfund.org/publications/issue-briefs/2022/apr/health-and-health-care-women-reproductive-age] ("Racial inequities are not unique to women in the U.S., however. In the

reasons to explain this disparity stem from medical professionals spending less time with Black patients, ignoring their symptoms and complaints, and losing contact with Black patients "during the postpartum period when women undergo major physiological changes that put them at risk of death."[89] In New York City, women of color are more likely to suffer from maternal mortality than Whites.[90]

Another barrier to receiving quality care could be that Medi-Cal recipients are treated differently than people with private health insurance. For instance, some people believe that because there is a low reimbursement rate for doctors that serve Medi-Cal patients, those patients are treated differently. "Some practitioners said there's the constant back-of-the-mind feeling that they're not going to be paid on time, so if they accept Medi-Cal patients, they're subsidizing their service, because they could go to private insurance and get paid quickly."[91] When the California Black Health Network went on a listening tour to better understand the needs of Black patients across the state, one common complaint was the stigma of Medi-Cal.[92] Even people who are eligible for Medi-Cal may not use it out of fear of being treated differently.[93]

Although these experiences do not encapsulate every individual person's relationship with the medical field, the insights above do help to explain why people of color, in general, distrust medical professionals. This context is important in light of the COVID-19 pandemic where people of color, on average, suffered greater transmission and death rates. The rapid spread of the COVID-19 virus, especially among people of color, did not happen equally. Thus, the context above helps frame the next section on why people of color experienced a greater disparity when it came to accessing COVID-19 testing and treatment.

II. THE IMPACT OF THE CORONAVIRUS ON PEOPLE OF COLOR

Nationally, Blacks, Latino/x, and Native Americans experienced disproportionate rates of COVID-19 infections and mortality. Black people are 12.4% of the population in the U.S. but suffered 18.5% of COVID-19 deaths.[94] Black people were disproportionately impacted by COVID-19 deaths in fifteen states and the District of Columbia by "at least ten percentage points."[95] In twenty-three states that tracked racial and ethnic data on the COVID-19 virus, American Indian and Alaskan Native people were diagnosed three and a half times more than White people.[96] Native Americans are 11% of the population in New Mexico, yet

U.K., for example, Black women are four times more likely than [W]hite women to die in pregnancy and childbirth.").

89. *Id.*

90. Elizabeth A. Howell & Jennifer Zeitlin, *Improving Hospital Quality to Reduce Disparities in Severe Maternal Morbidity and Mortality*, 41 SEMINARS IN PERINATOLOGY 266, 266 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5592149/ [perma.cc/RBY6-ZZQ9].

91. Caitlin Yoshiko Kandil, *Thousands of Medi-Cal Patients Report Poor Treatment by Doctors, Staff*, CAL. HEALTH REP. (Aug. 16, 2018), https://www.calhealthreport.org/2018/08/16/thousands-medi-cal-patients-report-poor-treatment-doctors-staff/ [perma.cc/FV7B-LRAX].

92. *Id.*

93. *Id.*

94. Goodwin & Chemerinsky, *supra* note 10, at 332.

95. *Id.*

96. *Id.* at 335.

were 37% of the COVID-19 infections and 26% of the deaths.[97] By mid-May 2020, the Navajo Nation–with approximately two hundred thousand members–had the highest infection rate per capita in the country.[98] More than 30% of the Navajo Nation lives without access to tap water or a toilet, in comparison to 0.5% of all Americans and 12% of Indian tribes.[99] The lack of access to water may have contributed to Navajo members being unable to wash their hands as often to prevent the spread of the virus.[100] Additionally, food deserts also may have presented a problem due to the lack of grocery stores in Navajo communities, which meant more people in a limited number of stores.[101] The lack of housing in Navajo communities also led to overcrowding, which likely increased the transmission of the virus.[102] Additionally, the COVID-19 virus impacted 10% of the Mississippi Band of Choctaw Indians and killed at least eighty-one people.[103]

Nationally, Latino/x communities were three times more likely to become infected by COVID-19 than their White counterparts.[104] In 2022, LA County's age adjusted death rate for Latino/x was two and a half times higher than the rate for White residents.[105] The Department of Public Health of LA County reported that in 2020 the age adjusted mortality rate for Black people was twice as high than for White people.[106] Moreover, in NYC, during the 2021 COVID-19 Omicron wave Latino/x saw higher rates of hospitalization, although not as high as the rates experienced by Black residents.[107] Some of the reasons for the high rates of hospitalization among Black and Latino/x people was the inability to work from home compared to Whites and Asians.[108] Thus, this meant greater exposure to COVID-19 in the workplace and the likelihood of spreading the virus to other members of the household.[109] Moreover, many Latino/x people work in private homes as domestic workers and these jobs were excluded from Cal/OSHA[110] benefits, such as paid sick leave for a COVID-19 infection.[111] Black and Hispanic workers made up 14% and 18% of the labor force in New York, but constituted 22% and 20% of essential workers, respectively; thus, this likely led to more

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97. Yearby & Mohapatra, *supra* note 1, at 2.

98. Goodwin & Chemerinsky, *supra* note 10, at 333.

99. *Id.* at 335.

100. *Id.*

101. *Id.*

102. *Id.* at 336.

103. *Id.* at 333–34.

104. *Id.* at 336–37.

105. DEP'T OF PUB. HEALTH FOR THE CNTY. OF L.A., ADDRESSING THE NEEDS OF COMMUNITIES MOST IMPACTED BY COVID-19: STRATEGIES IN SERVICE OF LOS ANGELES COUNTY'S LATINO/X RESIDENTS 12 (2022).

106. DEP'T OF PUB. HEALTH FOR THE CNTY. OF L.A., ADDRESSING THE NEEDS OF COMMUNITIES MOST IMPACTED BY COVID-19: STRATEGIES IN SERVICE OF LOS ANGELES COUNTY'S BLACK/AFRICAN AMERICAN RESIDENTS 12 (2022).

107. N.Y.C. HEALTH, RACIAL INEQUITIES IN COVID-19 HOSPITALIZATIONS DURING THE OMICRON WAVE IN NYC 4 (2022).

108. *Id.*

109. *Id.*

110. DEP'T OF PUB. HEALTH FOR THE CNTY. OF L.A., *supra* note 105, at 14.

111. *California's 2022 COVID-19 Supplemental Paid Sick Leave Expired on December 31, 2022*, CAL. DEP'T INDUS. RELS. (Mar. 2022), https://www.dir.ca.gov/dlse/COVID19Resources/2022-SPSL-FAQs.html [perma.cc/8GHP-2AME].

COVID-19 exposure.[112] In LA County, Latino/x workers were prevalent in workplaces such as "garment factories, meat processing plants, warehouses, grocery stores, hospitality, [and] public transportation."[113] A study by the CDC found that workers in agriculture and meat packing industries, who were predominantly Latino/x, were hit hard during the COVID-19 pandemic.[114] In July of 2020, almost 90% of meatpacking workers had COVID-19 and over half of those infected were Latino/x people.[115]

New York City observed lower rates of booster doses among Black people in 2021, partly because fewer received their first dose.[116] From October 1, 2020 to October 31, 2021, New York City observed delays in testing for Black residents in certain census tracts mainly because of decreased access to COVID-19 testing or no time off of work to get the test.[117] The CDC reported that Black Americans have been 22% less likely than White Americans to receive monoclonal antibody treatment for COVID-19, which was shown to decrease the risk of hospitalization.[118] In communities that were predominantly people of color, hospitals experienced greater workforce shortages during the Omicron surge and had less resources available.[119] Furthermore, people of color in LA County experienced difficulties securing online appointments due to limited comfortability with or access to technology, a lack of access to testing or vaccination sites, misinformation, and the distrust of unfamiliar pop-up sites administering tests or vaccinations.[120]

The disproportionate impact of COVID-19 is better understood when looking through a historical and cultural lens. The discussion in Part I of this Note presented insights on a person's job and healthcare coverage, the lack of quality hospitals in communities of color, and the distrust of medical professionals can help explain the disparities that were reported during the peak of the COVID-19 pandemic. Although quality healthcare may seem too expensive for some Americans, COVID-19 revealed the gross disparities in healthcare access based on race. A survey conducted in California showed that people with an income less than 200% of the federal poverty line were more likely to indicate affordable health care as an "extremely" and "very important" issue for the government to prioritize.[121] Given that low-income people, in general, suffer the most when it comes to the lack of healthcare access, affordable solutions are needed to address the health gap. Does affirmative action for healthcare make sense? From the history of forced sterilization and experiments on people of color, the U.S. medical field has created a distrustful relationship among certain groups of people. Based on this history of discrimination, the next section will evaluate whether race-based health policies are

112. MEREDITH BARRANCO, DAVID HOLTGRAVE & ELI ROSENBERG, DIFFERENTIAL IMPACTS OF COVID-19 IN NEW YORK STATE 4 (2020).

113. DEP'T OF PUB. HEALTH FOR THE CNTY. OF L.A., *supra* note 105, at 14.

114. Goodwin, *supra* note 10, at 337.

115. *Id.* at 338.

116. N.Y.C. HEALTH, *supra* note 107, at 5.

117. *Id.* at 6.

118. *Id.* at 8.

119. *Id.* at 11.

120. DEP'T OF PUB. HEALTH FOR THE CNTY. OF L.A., *supra* note 106, at 13–14.

121. BAILEY ET AL., *supra* note 25, at 4.

justified given the historical context of race and healthcare access in the United States, in addition to the racial health disparities during the COVID-19 pandemic.

III. HEALTHCARE ACCESS AND THE SUPREME COURT'S STRICT SCRUTINY TEST

In 2020, then-President Donald Trump declared a national emergency during the COVID-19 pandemic, which was eventually extended by President Biden.[122] Because of the impact of COVID-19, particularly on people of color, states such as Utah, Minnesota, and New York implemented race-based policies to disperse monoclonal antibodies to help prevent COVID-19. This Part will evaluate whether these race-based policies could withstand the strict scrutiny test implemented by the Supreme Court.

A. The Strict Scrutiny Test

When a governmental entity uses an explicit race classification in a law, the government could face legal challenges. A court of law will use the Supreme Court's standard of review set forth in *Adarand Constructors v. Pena* to assess the legality of the law under the Fourteenth Amendment's Equal Protection Clause. The Fourteenth Amendment guarantees equal protection of the law to all people regardless of racial identity. The strict scrutiny test requires that the government have a compelling state interest for the law, and the law must be narrowly tailored to achieve the government's interest.[123] The law is presumed unconstitutional, and the government bears the burden to show that the law is constitutional.[124] In order to show a compelling state interest, first the government must show that there was a history of discrimination or exclusion of the racial group by the government or state actor.[125] Secondly, the discrimination was de jure, or in other words, explicitly discriminatory; de facto discrimination is not enough.[126] The Court in *Milliken v. Bradley* reasoned that *Brown v. Board of Education* did not give a right to be free from de facto segregation but only a right of individuals to be free from de jure segregation.[127] Third, a general disparate impact alone is insufficient to allow for a race classification in the law; the government must show there was exclusion of a racial group to justify using a racial classification in the law.[128] Next, in order for the government's law to be narrowly tailored, the Court will assess various factors including: the law's (1) over-[129] or underinclusiveness,[130] (2) whether the law uses the least restrictive means to accomplish the government's goal,[131] and (3) if the government shows that other race-neutral alternatives were explored.[132] A law is

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122. 50 U.S.C. § 1621.

123. Adarand Constructors, Inc. v. Pena, 515 U.S. 200, 202 (1995).

124. *Id.* at 201.

125. *See* Richmond v. J.A. Croson Co., 488 U.S. 469, 499 (1989).

126. *Id.* at 506.

127. Milliken v. Bradley, 433 U.S. 267, 282–83 (1977).

128. *See Richmond*, 488 U.S. at 505.

129. *See id.* at 506.

130. *See* Eisenstadt v. Baird, 405 U.S. 438, 454 (1972) (reasoning that a state law violated the Fourteenth Amendment's Equal Protection Clause because it was underinclusive by excluding unmarried people from obtaining contraceptives).

131. City of Boerne v. Flores, 521 U.S. 507, 534 (1997).

132. *See Richmond*, 488 U.S. at 507, 509.

underinclusive when it does not capture all people who are similarly situated.[133] A law is overinclusive when it regulates more people than it needs to in order to accomplish its purpose.[134]

B. Race-Based Policies During the COVID-19 Pandemic

During the COVID-19 pandemic, the FDA allowed states to treat COVID-19 symptoms using monoclonal antibodies.[135] Monoclonal antibodies are proteins to help fight viruses like COVID-19.[136] Because of the scarcity of these antibodies, the state of Utah developed a risk factor calculator to distribute the antibodies.[137] Some Utah residents automatically qualified for the program because research found that unvaccinated pregnant women, long-term care facility residents, or people with immunocompromising condition were more likely to suffer from COVID-19.[138] Race was not an automatic qualifier but one of several factors that Utah used to determine eligibility alongside other factors such as "sex, age, pre-existing conditions, and current symptoms."[139] Each factor was assigned a number of points to determine who qualified.[140] A person had to score 10 points if they were vaccinated, or 7.5 points if they were unvaccinated.[141] Research found that Latino/x people were 35 to 50% more likely to be hospitalized due to COVID-19 in Utah; thus, if a person was non-White or Latino/x then they received two points.[142] Arguably, Utah's point system mirrors the case of *Gratz v. Bollinger*, where the University of Michigan had a point system for undergraduate admissions.[143] Michigan's policy ranked applicants on a 150-point scale and allocated certain points based on grade point average, test results, and personal achievements.[144] An applicant received an automatic twenty points if he or she was a member of an underrepresented minority group, attended a predominantly minority or disadvantaged high school, or was recruited for athletics.[145] The Court held this policy was unconstitutional under the Fourteenth Amendment because the point system was not individualized to a person's race or ethnicity, so it was not narrowly tailored.[146] The Court reasoned that race was used as a decisive factor regardless of the person's qualifications in comparison to a person that was not from an underrepresented group.[147]

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133. ERWIN CHEMERINSKY, CONSTITUTIONAL LAW 698 (6th ed. 2020).
134. *Id.* at 701.
135. UTAH DEP'T OF HEALTH, MONOCLONAL ANTIBODIES FOR TREATMENT OF COVID-19, https://coronavirus-download.utah.gov/Health/Monoclonial_Antibodies.pdf [perma.cc/FCA4-SVB8].
136. *Id.*
137. Joe Dougherty, *UDOH Statement on COVID-19 Treatment Risk Score Calculator*, UTAH DEP'T OF HEALTH AND HUM. SERVS. (Jan. 11, 2022), https://dhhs.utah.gov/featured-news/udoh-statement-on-covid-19-treatment-risk-score-calculator/ [perma.cc/NXV9-C82B].
138. *Id.*
139. *Id.*
140. *Id.*
141. *Id.*
142. *Id.*
143. Gratz v. Bollinger, 539 U.S. 244, 255 (2003).
144. *Id.*
145. *Id.* at 278.
146. *Id.* at 274–75.
147. *Id.* at 274.

Similar to the case of *Grutter v. Bollinger*, Utah could claim that using race as a factor operated like a "plus factor."[148] In *Grutter*, the University of Michigan's Law School considered race as a "plus factor" for admissions.[149] This was challenged based on the Fourteenth Amendment by a Michigan resident who was White .[150] The Court held that the affirmative action program by the law school was constitutional because racial diversity was a compelling state interest in order to add to the diversity of the classroom and educational enrichment of the student body.[151] However, the majority opinion reasoned that to be "narrowly tailored, a race-conscious admissions program cannot use a quota system," such that the program cannot "insulate" race as a qualifying factor separate from the other competing applicants.[152]

For the case of Utah's antibodies program, if race was not used as a "point system" but rather in a less decisive way, then perhaps the program would be narrowly tailored enough to survive the strict scrutiny test. For instance, if race was considered holistically in addition to other factors like age and pre-existing health conditions, then perhaps Utah's program would not be so similar to *Gratz*. The issue in *Gratz* was that race gave additional points to a student, irrespective of their other qualifications, which the Court saw as a disadvantage to students with higher qualifications but who were not from a racial minority background. But, if Utah's program was more holistic, then their antibody program would constitute a compelling state interest based on the number of Latino/x people hospitalized by COVID-19. Additionally, as long as race does not automatically place a racial minority ahead of others with equal or higher qualifications, then using race to allocate monoclonal antibodies may survive the strict scrutiny test.

However, Utah's program most resembled the *Gratz* point system. Thus, if the program was challenged on constitutional grounds, it is possible that the Court would see this as resembling a quota system and rule the program unconstitutional. Likely, using race as a factor for the distributing the monoclonal antibodies would constitute a compelling state interest for Utah because minorities, in particular Latino/x people, were hospitalized from COVID-19 at a higher rate than White people. However, there would likely not be enough evidence to show that Utah had historically discriminated against people of color to justify using race as a factor to determine eligibility for the monoclonal antibodies. Even if there was a compelling state interest to justify using race and ethnicity as a qualifying factor under Utah's program, the program would not have been narrowly tailored.

Instead of using race, Utah could have assigned a point system based on zip codes similar to California. To address the communities that were most impacted by COVID-19 infections, California administered a Healthy Places Index (HPI) formula with twenty-five characteristics to determine COVID-19 vaccination allocation.[153] Some of these factors included socioeconomics, "education,

148. Grutter v. Bollinger, 539 U.S. 306, 334 (2003).

149. *Id.* at 341.

150. *Id.* at 316–17.

151. *Id.* at 315.

152. *Id.* at 334.

153. CAL. DEP'T OF PUB. HEALTH, FACT SHEET: ENDING THE PANDEMIC THROUGH EQUITABLE VACCINE ADMINISTRATION 1 (2021), https://www.gov.ca.gov/wp-content/uploads/2021/03/Equitable-Vaccine-Administration-Fact-Sheet.pdf [perma.cc/6D2W-6TQU].

healthcare access, housing, neighborhoods, clean environment, [and] transportation," among others.[154] The zip codes with the highest scores had better health outcomes and those with the lowest scores had the worst health outcomes.[155] So, California used the HPI formula to determine which areas would receive the greatest number of vaccinations.[156] Therefore, the Court would likely reason that it was possible for Utah to use racially neutral means to accomplish allocating monoclonal antibodies based on need. Using race may have been a more expedient way to disburse the antibodies, but there are other factors to consider. As referenced in the above discussion, where a person lives has an impact on their access to quality healthcare. So, using zip codes combined with other factors like socioeconomic status, housing density, and access to transportation could have been better factors than race.

Furthermore, Minnesota also considered race and ethnicity when the FDA authorized emergency use of monoclonal antibodies.[157] Based on the CDC's analysis that race and ethnicity could place individuals at a higher risk of a severe COVID-19 infection, Minnesota recommended that their health officials consider race and ethnicity to administer the monoclonal antibodies.[158] One source indicated that the Minnesota program had a similar point system to that of the Utah program.[159] In January of 2022, both Minnesota and Utah removed the race factor from their monoclonal antibodies program due to the threat of a lawsuit.[160] Utah, instead, decided to create greater access to the antibodies by placing medication in closer proximity to diverse communities.[161]

The New York State Department also allowed race to be a factor for eligibility of its limited supply of monoclonal antibodies.[162] These race-based allocation programs were met with controversy because an individual that was non-White could be given life-saving treatment over a similarly situated White person.[163] A conservative group led by former President Donald Trump's advisor, Stephen Miller, wrote a letter stating that "the color of one's skin is not a medical

154. *Id.*

155. *Id.*

156. *Id.*

157. MINN. DEP'T OF HEALTH, ETHICAL FRAMEWORK FOR ALLOCATION OF MONOCLONAL ANTIBODIES DURING THE COVID-19 PANDEMIC 13 (2021), https://www.lrl.mn.gov/docs/2022/other/220445.pdf [perma.cc/CQ4B-YZBE].

158. *Id.*

159. Michael Conklin, *Legality of Explicit Racial Discrimination in the Distribution of Lifesaving COVID-19 Treatments*, 19 IND. HEALTH L. REV. 315, 318 (2022).

160. Xander Landen, *Utah, Minnesota Back Down on Race-Based COVID Care as New York Faces Lawsuit*, NEWSWEEK (Jan. 23, 2022, 4:11 PM), https://www.newsweek.com/utah-minnesota-back-down-race-based-covid-care-new-york-faces-lawsuit-1672011 [perma.cc/S38P-K9T6].

161. *Id.*

162. N.Y.C. DEP'T OF HEALTH & MENTAL HYGIENE, COVID-19 ORAL ANTIVIRAL TREATMENTS AUTHORIZED AND SEVERE SHORTAGE OF ORAL ANTIVIRAL AND MONOCLONAL ANTIBODY TREATMENT PRODUCTS 3 (2021), https://www.nyc.gov/assets/doh/downloads/pdf/han/advisory/2021/covid-19-oral-treatments-authorized-shortage.pdf [perma.cc/X44M-Z493].

163. Conklin, *supra* note 159, at 319.

condition . . ."[164] The group also said that "[n]o right is safe if the government can award or deny medical care based on race."[165]

The most recent Supreme Court decision in *Students for Fair Admissions, Inc. v. President and Fellows of Harvard College* (*SFFA*) held that consideration of race for college admissions by Harvard University and the University of North Carolina's (UNC) failed the strict scrutiny test.[166] Both UNC and Harvard considered race, among other factors, for admissions.[167] For the first-prong of the strict scrutiny test (a state must have a compelling state interest), the Court in *Grutter* reasoned that diversity on college campuses is a compelling interest for universities,[168] but the Court in *SFFA* came to a different conclusion..[169] Harvard and UNC justified using race in admissions because it helped to educate students, adapt to a diverse society outside of an educational institution, develop new ideas and perspectives, and increase empathy and cultural understanding.[170] Yet, the Court held that believing minority students hold a particular point of view simply because they are a minority is a stereotype and impermissible reason to use race.[171] Another reason the Court rejected using race in admissions to higher education institutions was that there was no end in sight.[172] The Court found that the way that race was factored into Harvard's admission process supported a never-ending use of race as a factor for admissions.[173]

The decision in *SFFA* does not ultimately reject using race for college admissions; however, the Court did reject the justifications given by Harvard and UNC for using race in their college admissions process. The Court stated in *SFFA* that race could be considered in a college admission's essay to speak to a student's uniqueness or leadership.[174] Yet, this still does not provide clarity on whether race can actually be considered because the Court also said that "universities may not simply establish through application essays or other means" race as an admissions factor . . . . '[W]hat cannot be done directly cannot be done indirectly.'"[175] As of today, there is uncertainty as to what constitutes a compelling state interest and whether that interest is narrowly tailored enough to justify using race for college admissions.

This same question can be applied to using race as a factor for healthcare programs, like allocating monoclonal antibodies or COVID-19 vaccinations. Given the recent Court decision in *SFFA*, the dispersal of monoclonal antibodies by Utah, Minnesota, and New York may be deemed a compelling state interest depending on

164. Ronny Reyes, *Utah, Minnesota Face Legal Threats for Using Race as a Factor to Determine COVID Treatment Eligibility as Non-Whites Were at Greater Risk for Hospitalization*, DAILY MAIL.COM (Jan. 13, 2022), https://www.dailymail.co.uk/news/article-10396877/Utah-Minnesota-face-legal-threats-using-race-determine-COVID-treatment-eligibility.html [perma.cc/396A-ECRQ].

165. *Id.*

166. Students for Fair Admissions, Inc. v. President & Fellows of Harv. Coll., 600 U.S. 181, 217–18 (2023).

167. *Id.* at 195–97.

168. Grutter v. Bollinger, 539 U.S. 306, 325 (2003).

169. *SFFA*, 600 U.S at 230.

170. *Id.* at 214.

171. *Id.* at 220.

172. *Id.* at 224–26.

173. *Id.* at 225.

174. *Id.* at 230.

175. *Id.* at 230 (quoting Cummings v. Missouri, 71 U.S. 277, 325 (1866)).

the reasoning given to justify using race as a factor. The Court could find that the disproportionate number of people of color who were hospitalized and died as a result of COVID-19 is a compelling interest to disperse monoclonal antibodies, or other life-saving treatment like COVID vaccines based on race. In *SFFA*, the Court overruled using race as a plus factor and so effectively overturned *Grutter*, except where race can be seen as a compelling interest.[176] The Court in *SFFA* reasoned that measuring the impact of race in admissions would be difficult and immeasurable.[177] But, unlike the rationale used by Harvard and UNC to justify using race for admissions decisions to achieve empathy and new perspectives for their students, using race in the health context is compelling given that COVID-19 did impact people of color at higher rates, which is measurable. Also, unlike the *SFFA* opinion, where the Court argued that the admissions policy relies on the stereotype that minority students possess a unique point of view, using race-based health policies does not rely on a stereotype but rather on statistical data of COVID-19 infections. In the case of the COVID-19 pandemic, the justification for race would be to ensure that the most impacted people receive expeditious medical treatment.

But having a compelling reason to use race is not enough to meet the high standard of strict scrutiny. In the case of race-based health policies, the Court would likely find that dispersing life-saving treatment based on race is not narrowly tailored and could be achieved by other means, such as California's use of zip codes to determine the communities most impacted by COVID-19.[178] The Court may also point to other alternatives, such as LA's strategy to partner with community organizations to reach people who are fearful of medical treatment. The Court in *SFFA* focused more on the first prong of the strict scrutiny test and less on the second prong which requires that the policy or law be narrowly tailored to achieve the compelling interest. The Court in *Fisher v. University of Texas at Austin* accepted the use of race in college admissions as narrowly tailored to achieve diversity.[179] In this case, the University tried using racially neutral admission alternatives but did not achieve the same results as using a race-conscious admissions policy.[180] More specifically, the school obtained higher numbers of Latino/x and Black applicants when using a race-conscious admissions policy.[181] The Court highlighted that the University implemented race neutral options to achieve diversity such as creating "three new scholarship programs, open[ing] new regional admissions centers, increase[ing] its recruitment budget by half-a-million dollars, and organiz[ing] over 1,000 recruitment events."[182] But, the University was unable to achieve the diversity that it did through a race-conscious admissions policy.[183] Therefore, the Court

176. *See SFFA*, 600 U.S. at 211.

177. *Id.* at 244.

178. Although, the COVID-19 pandemic was a national emergency justifying race-based health policies using the Court's reasoning in *Korematsu* will not be analyzed in this Note because the Court has since said that *Korematsu* is a bad precedent and no longer followed. *SFFA*, 600 U.S. at n.3 ("We have since overruled *Korematsu*, recognizing that it was 'gravely wrong the day it was decided'") (quoting Trump v. Hawaii, 585 U.S. 667, 710 (2018)).

179. Fisher v. Univ. of Texas, 579 U.S. 365, 382 (2016).

180. *Id.*

181. *Id.* at 384.

182. *Id.* at 385.

183. *Id.*

determined that using race as a factor for admissions was more effective than other race neutral options.[184]

Fisher was not overruled by the Court's decision in *SFFA*. Therefore, using race could pass the strict scrutiny's narrowly tailored prong if, like the University of Texas, a state could show that using race neutral options are not as effective in allocating monoclonal antibodies or COVID-19 vaccines. Like in *Fisher*, a state could justify the use of race-based health policies by producing "sufficient measurable" data to show that using race is more effective for allocating COVID-19 treatment than using race neutral options. If states like Utah, Minnesota, and NY wanted to show that there was no other way to effectively disperse life-saving treatment during COVID-19, then similar to the University of Texas, these states would likely need to also show that using race-based health policies is more effective than race neutral options.

C. The Efficacy of Race-Based Health Policies

If race-based health policies from New York, Minnesota, and Utah were to go through the litigation process the courts would apply the strict scrutiny test. An article by Michael Conklin articulated that the race-based health policies implemented during COVID-19 would fail the strict scrutiny test.[185] First, Conklin argued that there was no evidence of intentional discrimination by any of these states and statistical disparities are not enough to prove a compelling state interest.[186] Conklin also made the argument that the race-based policies would fail the narrowly tailored prong of the strict scrutiny test.[187] He explained that Latino/x and Black people were more likely to have medical comorbidities, such as obesity and chronic kidney disease.[188] When controlling for age, sex, socioeconomic status and the medical conditions listed previously, Latino/x and Blacks statistically had a slightly better survival rate compared to Whites.[189] Thus, Conklin used this study to show that other racially neutral alternatives such as age or health conditions are viable factors to use instead of race as eligibility criteria for life-saving treatments to fight a COVID-19 infection.[190]

Furthermore, Conklin argued that race and comorbidities are interrelated, so by counting race and comorbidities for eligibility criteria in race-based health programs, the same factor is being counted twice.[191] Additionally, Conklin argued that the race-based policies are overinclusive because Asians were also included in the racial and minority factor for the monoclonal antibody programs, yet Asians were less likely to get COVID-19, be hospitalized, or die from COVID-19

184. *Id.* at 387–88.
185. Conklin, *supra* note 159, at 320.
186. *Id.* at 319–20.
187. *Id.* at 321.
188. *Id.* at 316.
189. Rafi Kabarriti, N. Patrik Brodin, Maxim I. Maron, Chandan Guha, Shalom Kalnicki, Madhur K. Garg & Andrew Racine, *Association of Race and Ethnicity With Comorbidities and Survival Among Patients With COVID-19 at an Urban Medical Center in New York*, JAMA Network Open (Sept. 25, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2770960 [web.archive.org/web/20201208041953/https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2770960].
190. Conklin, *supra* note 159, at 321–22.
191. *Id.*

compared to Whites.[192] However, 2022 data suggests that Asians actually experienced higher rates of COVID-19 infection compared to Black and Latino/x people.[193] Conklin also argued that analogizing race-based health programs to educational affirmative action cases is incomparable because COVID-19 treatment is life-saving and far more significant than a person getting into a top college of his or her choice.[194] If race-based policies were raised as an issue at the Supreme Court level, the policies would likely fail given the Court's composition. As noted in Conklin's article, the Court will not see preference of race as a compelling state interest or narrowly tailored.[195] This is evident by Chief Justice Roberts opinion in *Parents Involved in Community Schools v. Seattle School District No. 1*,[196] where he stated, "the way to stop discrimination on the basis of race is to stop discriminating on the basis of race."[197]

Lastly, Conklin appealed to policy arguments to justify why race-based health policies are not a sound option. He argued that race-based health policies could lead to greater government distrust because people could see these policies as "immoral and inefficient."[198] Interestingly, he cited the Tuskegee Syphilis Study to say that race-based policies could trigger the misuse of medical treatment on Black people.[199] Moreover, he points out that the race-based policies could lead to resentment, people thinking that minorities are genetically different, or normalizing racial discrimination by the government.[200]

Although minority groups faced greater hospitalization and death due to COVID-19, the New York, Minnesota, and Utah programs would likely fail the strict scrutiny test. Some of the reasons highlighted by Conklin speak to why the programs would fail the strict scrutiny test. However, more importantly, likely none of the race-based policies can be justified because there was no discriminatory intent by the government to exclude minority groups from seeking COVID-19 treatment. Moreover, a compelling reason why the narrowly tailored test would fail is because states, such as California, did consider other racially neutral alternatives to distribute COVID-19 treatment. Thus, the program in California undermines the justification for using specific race-based policies in health care treatment. But, as stated in *Fisher*, just because race-neutral options exist does not mean race neutral options are as effective as race-conscious options. Therefore, a comparative analysis would need to be conducted to determine whether race-based health policies were a more effective way to allocate COVID-19 treatment than race neutral options implemented in states like California.

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192. *Id.*

193. Latoya Hill & Samantha Artiga, *COVID-19 Cases and Deaths by Race/Ethnicity: Current Data and Changes Over Time*, KFF (Aug. 22, 2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/covid-19-cases-and-deaths-by-race-ethnicity-current-data-and-changes-over-time [perma.cc/QCS5-L9VZ].

194. Conklin, *supra* note 159, at 323–24.

195. *Id.* at 320.

196. *Id.* at 324.

197. *Id.* (quoting Chief Justice Roberts in Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1, 551 U.S. 701, 748 (2007)).

198. *Id.*

199. *Id.* at 325.

200. *Id.*

Because of the history of mistrust that minority groups have of medical professionals, using race is not an effective way to deliver health treatment. In fact, using race-based health policies could provoke skepticism and fear that already exists among some people of color. Using race as a factor in healthcare could be a reminder of when the government embarked on racially motivated health programs like the Tuskegee study or forced sterilization. Although race may not be the best course of action to achieve better health outcomes for minority groups, efforts should be made to reach racial and ethnic minorities who do experience less healthcare quality and access. Meaningfully addressing racial health disparities can be accomplished without using explicit race-based policies. Using explicit race-based policies runs the risk of litigation could derail and distract from people of color receiving quality healthcare. Instead, other alternatives should be used to increase trust and deliver quality care to communities that need it the most.

IV. LEGAL AND POLICY CONSIDERATIONS TO ADDRESS RACIAL HEALTH DISPARITIES

The way to address delivering and creating greater access to healthcare is not through race-based policies. Other measures can be taken in order to address the distrust that people of color have of medical professionals delivering quality healthcare. First, greater data collection on race, ethnicity, gender, and socioeconomic status is needed to fully understand health care access and quality.[201] Additionally, in LA County, a report noted that some Black people felt distrust with unfamiliar COVID-19 "pop-up" sites in their communities.[202] Partnering with community-based organizations (CBOs) that are trusted and familiar in areas with high populations of people of color can help improve healthcare access.[203] This practice should not be a one-time occurrence as a response to a public health crisis. State health departments can partner with CBOs and local elected officials to consistently deliver information on vaccines and other health-related information.

One study showed that capital assets of healthcare organizations, such as facilities and equipment, for communities of color impacted quality care.[204] Thus, greater state and federal investments in healthcare facilities in low-income census tracts could help improve quality healthcare. Low-income neighborhoods experienced greater staffing shortages during the pandemic,[205] so increasing the pipeline of healthcare workers reflective of the community they are serving could help reduce wait times for people to receive care. Strategies for achieving greater diversity in the medical profession have already been in development, even after the *SFFA* decision.[206]

201. John P.A. Ioannidis, Neil R. Powe & Clyde Yancy, *Recalibrating the Use of Race in Medical Research*, 325 AM. MED. ASS'N 623, 624 (2021).

202. DEP'T OF PUB. HEALTH FOR THE COUNTY OF L.A., *supra* note 106, at 14.

203. *Id.*

204. Himmelstein & Himmelstein, *supra* note 29.

205. N.Y.C. HEALTH, *supra* note 107, at 11.

206. Asees Bhasin & Gregory Curfman, *Gutting* Grutter*: The Effect of the Loss of Affirmative Action on Diversity Among Physicians*, 20 IND. HEALTH L. REV. 1, 19–20 (2023).

A. Developing a Diversity Pipeline into the Medical Profession

The director of workforce studies for the Association of American Medical Colleges suggested that one of the reasons for the lack of Black physicians is the history of exclusion of Black people from the medical profession.[207] Until the passage of the CRA, Blacks were prevented from becoming doctors.[208] Today, a total of 5.7% of doctors are Black, 6.9% are Hispanic, and less than 1% are American Indian or Alaska Native.[209] Almost 64% of physicians identify as White, and 20.6% identify as Asian.[210] General mistrust of public health professionals, in general, prevails among people of color. One way to increase trust is for physicians and medical professionals to resemble the community they are seeking to help. Increasing diversity in the medical profession may not only help patients gain trust in their medical professionals but also help with outcomes in the medical profession. For instance, a study on hospital births in Florida from 1992 to 2015 found that there was reduced infant mortality for Black newborn infants when the newborns were cared for by Black physicians compared to White physicians.[211] Moreover, other studies have found that minority patients are more likely to choose another minority physician and have greater satisfaction when seen by someone from a minority background.[212]

Increasing diversity in the medical profession may seem difficult given the Court's recent decision in *SFFA* striking down affirmative action in higher education. Currently, affirmative action is outlawed in eight states: Arizona, California, Florida, Michigan, Nebraska, New Hampshire, Oklahoma, and Washington.[213] A study published in 2022, conducted from 1985 to 2019, showed that states with affirmative action bans, compared to states that did not have these bans, did experience a decline in minority enrollment at schools.[214] In 1996, California passed Proposition 209 banning affirmative action programs statewide, which led to a decrease in minority enrollment in higher education institutions.[215] In the *SFFA* case, the President and Chancellors of the University of California (UC) submitted a brief to the Court describing the impacts of banning affirmative action in higher education. For instance, there was a 50 percent or more decline of minority enrollment across UC's most selective schools.[216] At the University of

207. Jacqueline Howard, *Only 5.7% of US Doctors are Black, and Experts Warn the Shortage Harms Public Health*, CNN (Feb. 21, 2023, 7:01 AM), https://www.cnn.com/2023/02/21/health/black-doctors-shortage-us/index.html [perma.cc/H8K9-DQLX].

208. Song, *supra* note 5.

209. Bailey, *supra* note 7.

210. *Id.*

211. Bhasin & Curfman, *supra* note 206, at 13.

212. *Id.*

213. Office of the General Counsel, *States Where Race-Conscious Admissions Policies are Banned*, MIDDLEBURY UNIV., https://www.middlebury.edu/general-counsel/resources/harvard-and-unc-admissions-cases/states-where-race-conscious-admissions [perma.cc/2XJX-J9JH].

214. *Id.*

215. Laura Krantz, *As Affirmative Action Decision Looms, Colleges Look for Alternative Ways to Achieve Diversity*, BOSTON GLOBE (May 22, 2022), https://www.bostonglobe.com/2022/05/22/metro/affirmative-action-decision-looms-colleges-look-alternative-ways-achievediversity/?s_campaign=8315 [perma.cc/ZQK7-FF5A].

216. Brief for the President and Chancellors of the Univ. of Cal. as Amici Curiae Supporting Respondents at 4, Students for Fair Admissions, Inc. v. President & Fellows of Harv. Univ., 600 U.S. 181 (2023) (Nos. 201–1199, 21–707), 2022 WL 3108901.

California, Los Angeles (UCLA) the enrollment of Black and Native American students experienced a decline.[217] At UC Berkeley, an even greater decline occurred among enrolled Black and Native American freshman on campus.[218] Although Latino/x people are a larger proportion of the undergraduate applicant pool than other minority groups, the number of Latino/x students on campuses still falls short compared to their population size in California public schools.[219] Moreover, in 2006, the state of Michigan also banned affirmative action, and as a result the University of Michigan submitted a report to the Court describing the impact.[220] Michigan reported that a ban on affirmative action led to a decline of Black undergraduate enrollment from seven percent in 2006 to less than four percent in 2021, and a decline of Native Americans dropped from one percent to 0.11 percent.[221]

As a result of an affirmative action ban, California developed other ways to ensure diversity at colleges. One strategy that may help maintain diversity was implemented during the COVID-19 pandemic where some schools did not require standardized test scores.[222] In lieu of race, other strategies may include using socioeconomic status, eliminating legacy admission seats, recruiting from geographically diverse zip-codes, increasing financial aid, or increasing the admission of community college transfers.[223] After 1996, California colleges began recruitment in geographically diverse areas and even recruiting from churches and community centers.[224] Other strategies included a holistic application review process, which considered extracurricular activities, accomplishments outside of school, grade point averages, or essays talking about lived experiences.[225] Florida, Texas, and California have implemented a "top percent" program, which guarantees enrollment into their public universities for students who are in the top percentage of their high school classes.[226] However, academic studies, including the research from the University of California and the University of Michigan, have found that race-neutral options are not as effective as race-conscious strategies to increase diversity in higher education.[227]

Another strategy could be to begin recruitment and mentorship programs in middle school to engage diverse groups in the sciences and medical field generally.[228] Another idea could be to create a new medical school at a historically Black college and university (HBCU).[229] Overall, ensuring diversity in the medical

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217. *Id.* at 23–24.
218. *Id.* at 23.
219. *Id.* at 24.
220. Brief for the Univ. of Mich. as Amicus Curiae in Support of Respondents at 3, Students for Fair Admissions, Inc. v. President & Fellows of Harv. Univ., 600 U.S. 181 (2023) (Nos. 201–1199, 21–707), 2022 WL 3130736.
221. *Id.* at 22.
222. Krantz, *supra* note 215.
223. *Id.*
224. Bhasin & Curfman, *supra* note 206, at 20.
225. Denise-Marie Ordway, *Race-Neutral Alternatives to Affirmative Action in College Admissions: The Research*, JOURNALIST'S RES. (June 29, 2023), https://journalistsresource.org/education/race-neutral-alternatives-affirmative-action-college-diversity/ [perma.cc/EYQ5-HST3].
226. *Id.*
227. *Id.*
228. Howard, *supra* note 207.
229. Bhasin & Curfman, *supra* note 206, at 21.

profession can lead to increased trust among medical professionals and even better health outcomes for people of color. Thus, figuring out a strategy, in light of *SFFA*, is critical to maintaining and increasing diversity in the medical profession.

B. Increasing Healthcare Accessibility

Another gap identified in this Note is the lack of available healthcare across all industries. For instance, as described in the above discussion, Latino/x people represent a great number of people in the meatpacking industry. Due to this industry's essential function to the economy, there was not an opportunity to work from home. Therefore, in terms of vaccinations, health departments can also look to industries that may be more susceptible to transmitting viruses when work from home is not an option and prioritize those essential service workers. Additionally, people of color were more likely to work in jobs without healthcare insurance.[230] In order to increase access to healthcare, more people need to have health insurance available through their employers. Also, access to time off to receive health care services is a lesson learned from COVID-19. This is especially true given that people of color saw greater transmission rates of COVID-19 due to being essential workers.[231] In the case of the *National Federation of Independent Business v. Sebelius*, the Court held that states unwilling to participate in Medicaid expansion could not be forced to provide certain health coverage in order to receive federal funds.[232] The expansion of the Affordable Care Act (ACA) could have allowed for an increased access in healthcare coverage for low-income people, especially low-income people of color.[233] Although Medicaid expansion is not required of the states, the COVID-19 pandemic should have encouraged health departments to realize the importance of providing some level of health insurance coverage in order to prevent illness and death. According to the 2023 Scorecard on State Health System Performance, states that had not expanded Medicaid eligibility under the ACA—Mississippi, Georgia, Wyoming, Oklahoma, and Texas—had the lowest performing health outcomes.[234]

During the COVID-19 pandemic, more people were insured given the 2020 federal requirement that states keep Medicaid participants enrolled through the end of the public health emergency.[235] Additionally, several states expanded Medicaid eligibility which helped increase the number of insured residents.[236] Marketplace premium subsidies were also lowered by the Inflation Reduction Act until 2025 for eligible families; however, these will not last and millions will go uninsured.[237] Being

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230. Sohn, *supra* note 2, at 183.

231. Yearby & Mohapatra, *supra* note 1.

232. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 585 (2012).

233. JESSE CROSS-CALL, CTR. ON BUDGET AND POL'Y PRIORITIES, MEDICAID EXPANSION HAS HELPED NARROW RACIAL DISPARITIES IN HEALTH COVERAGE AND ACCESS TO CARE (2020), https://www.cbpp.org/sites/default/files/atoms/files/10-21-20health2.pdf [perma.cc/GTG9-KP4S].

234. David C. Radley, Jesse C. Baumgartner, Sarah R. Collins & Laurie C. Zephyrin, *2023 Scorecard on State Health System Performance*, COMMONWEALTH FUND (June 22, 2023), https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance#6 [web.archive.org/web/20230622094747/https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance].

235. *Id.*

236. *Id.*

237. *Id.*

uninsured is one problem, but another is being "underinsured."[238] Underinsured means that even if people pay for health insured they still face high costs for healthcare.[239] In 2021, consumers held about $88 billion of medical debt.[240]

To improve health outcomes and increase quality care, an overall increase in the primary care workforce[241] and local recruitment of future medical health professionals is needed, so professionals serve in the communities they come from. One idea is to offer loan repayment for medical providers who serve in under-resourced communities.[242] States can develop goals to increase health services to under-resourced communities by using the lessons learned from the COVID-19 pandemic and target specific communities that have the worst health outcomes. States could model a program off of California's HPI formula, a formula mentioned in Part III of this Note, that identified twenty-five characteristics (healthcare access, clean environment, transportation, etc.) to determine COVID-19 vaccination allocation. Targeted outreach to diverse communities can also help to build trust of medical professionals. Targeted outreach and engagement in diverse communities can also help to address the pregnancy-related deaths faced by women of color. For instance, postpartum follow-up visits up to a year after giving birth to identify any pregnancy-related issues are crucial.[243] In a North Carolina review of maternal deaths were potentially preventable, with the need for higher quality care factoring into over one-half of these deaths.[244]

C. Implementing Empathy, Cultural Competency, and Implicit Bias Training

Another opportunity to increase trust and health outcomes is to address bias and stereotypes that may exist among medical professionals through training. Given that some people of color face negative experiences while interacting with medical professionals, there should be an emphasis on cultural competency training for all medical professions including paramedics, nurses, doctors, and hospital staff. As mentioned in Part I, some USC medical students experienced a culture shock when taking care of patients that were predominately people of color. Training to engage with people from diverse backgrounds is important for healthcare workers because the medical profession still lacks Black and Latino/x representation. This training becomes especially important for hospitals located in diverse metropolitan areas like Los Angeles and New York City.

A program led by X4 Health created a space where physicians and patients come together to share their experiences in the medical profession.[245] Both medical professionals and patients identified having more time for relationship building in order to get to know each other.[246] This model could be adopted by CBOs that

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238. *Id.*
239. *Id.*
240. *Id.*
241. *Id.*
242. *Id.*
243. *Id.*; *see also* Gunja, *supra* note 88 ("[E]xpanding the maternal care workforce to include more nurses, midwives, and doulas could improve perinatal and postpartum outcomes, particularly for people experiencing significant inequities in birth outcomes.").
244. Elizabeth A. Howell & Jennifer Zeitlin, *Improving Hospital Quality to Reduce Disparities in Severe Maternal Morbidity and Mortality*, 41 SEMINARS PERINATOLOGY 266, 268.
245. Hostetter & Klein, *supra* note 88.
246. *Id.*

already have an established relationship with certain communities, in order to connect doctors from medical centers and hospitals with community members through conversation and relationship building.

Also, implicit bias training and assessments are important to implement in order to improve the interactions of medical professionals and patients. Implicit biases are discriminatory biases based on hidden attitudes or stereotypes about a person or group.[247] Implementing assessments like surveys or other tools to identify implicit bias could be used to assess a patient's experience. Addressing diversity in the medical profession is not enough: efforts should be made to continuously educate existing medical professionals about potential implicit bias. The onus on minority groups to break down barriers is insufficient when the medical profession is predominately White. More should be done to integrate empathy and cultural competency training even at the medical school level and throughout a medical professional's career. In fact, emphasizing implicit bias could be lifesaving. In 2018, a fire department in Florida refused an ambulance to a Black woman who was passed out and drooling from the mouth.[248] The paramedics assumed she could not afford the ambulance service.[249] The paramedics also did not do "a medical evaluation . . . [or take her] blood pressure or temperature."[250] She eventually slipped into a coma and died five days later.[251] This incident highlights the need for medical professionals, who are often called upon in stressful and emotional situations, to seriously challenge their implicit biases. The type of medical care a person receives can be the difference between life or death. So, strict adherence to medical procedures and protocols is important to ensure each person, especially in life-threatening situations, receives the same adequate care.

Not only does implicit bias matter but also physicians should emphasize patients as participants in their care.[252] One study showed that "patient-centered communication" may reduce medical mistrust.[253] The study demonstrated that medical professionals that incorporated their patients' perspectives into decision-making are more likely to gain their trust and improve their understanding of medical treatment.[254] Compassionate communication between medical professionals and patients can help reduce implicit bias. One study found that Black patients were more likely than White patients to have a negative term used in their health record such as "refused, non-adherent, not compliant, and agitated."[255]

247. Anthony G. Greenwald & Linda Hamilton Krieger, *Implicit Bias: Scientific Foundations*, 94 CAL. L. REV. 945, 951 (2006).

248. Jen Christensen, *Mom Says Medics Didn't Take Daughter to Hospital, Saying She Couldn't Afford It*, CNN (July 31, 2018, 10:05 PM), https://www.cnn.com/2018/07/31/health/woman-dies-rescue-wont-take-her-cant-pay/index.html [perma.cc/MYK3-Q827].

249. *Id.*

250. *Id.*

251. *Id.*

252. Lauren Odum & Adam Whaley-Connell, *The Role of Team-Based Care Involving Pharmacists to Improve Cardiovascular and Renal Outcomes*, 2 CARDIORENAL MED. 243 (2012).

253. Adolfo G. Cuevas, Kerth O'Brien & Somnath Saha, *Can Patient-Centered Communication Reduce the Effects of Medical Mistrust on Patients' Decision Making?*, 38 HEALTH PSYCH. 325, 331 (2019).

254. *Id.* at 326.

255. Roni Caryn Rabin, *Doctors Are More Likely to Describe Black Patients as Uncooperative, Studies Find*, N.Y. TIMES (Feb. 16, 2022), https://www.nytimes.com/2022/02/16/health/black-patients-doctor-notes-diabetes.html [web.archive.org/web/20240718180034/https://www.nytimes.com/2022/02/16/health/black-patients-doctor-notes-diabetes.html].

Instead of using these terms, one doctor advocated that medical professionals should instead inquire as to why a person is not complying with a medical regimen by asking specific questions, rather than using a vague, negative term.[256] Doctors, nurses, and other medical professionals can help build greater trust and positive interactions among patients by communicating with compassion and understanding.

Moreover, adhering to ethical standards is especially important given the history of experimentation on people of color. In light of the Tuskegee Study, forced sterilization, and the more recent example of the Arkansas jail doctor giving incarcerated people a harmful COVID-19 "treatment" drug without their consent, hospitals and medical institutions should create and scrutinize their ethical standards to provide the highest quality of care. Healthcare is an industry, a business, led by public and private actors. But each of these actors should reflect on whether their policies and procedures are ensuring the best quality care for diverse populations. Unlike higher education where a student can choose whether or not to interact with people from diverse backgrounds, medical professionals have no choice. So, understanding the barriers people of color face when accessing healthcare is crucial to building trust and increasing positive interactions among medical professionals and patients. The recommendations listed here are just some solutions to help improve the mistrust in the medical field and access to quality healthcare services for people of color.

CONCLUSION

COVID-19 illuminated some of the gaps that exist in delivering quality healthcare to people of color. Race-based policies are not a solution to bridging this gap because race-neutral options can work and help avoid any litigation that could arise from explicitly using race-based policies. To adequately address quality care for people of color, there should be a focus on state health departments to build trust with people of color and financial investments in health facilities in communities with a lack of quality hospitals. Based on this country's history of nonconsensual experimentation and forced sterilization, people of color are owed better health outcomes and trusted healthcare providers. Some of the solutions presented are based on lessons learned from COVID-19. But it should not take a public health crisis to address the health gap for racial groups. If another public health outbreak were to occur, then some of the recommendations listed above would be needed for medical professionals to address the needs faced by people of color. More broadly, addressing the recommendations above could help improve the racial disparities in healthcare.

256. *Id.*