# THE FAILURE OF LITIGATION TO CHALLENGE RACISM IN HEALTH CARE

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## Abstract

In this article, I use a critical race approach and a civil rights of health framework to examine the role of racism in medical treatment, specifically of Black women. Because racism is built into our institutions, widespread in our culture, and influences our beliefs and behavior, it is necessary to recognize and understand its universal presence when determining the most effective method to confront its impact on patient care in the health care setting. The current civil rights doctrine is ineffective in addressing this insidious racism, which is why I propose a doctrinal shift in disparate impact claims and use patient narratives to demonstrate the need for this shift. This new doctrinal framework assumes the existence of bias once a patient has identified disparate impact, shifting the burden to the defendant to prove this impact was not a result of discrimination. This change removes the need for plaintiffs to identify a specific discriminatory policy or practice and acknowledges the pervasiveness of racism and implicit bias in our society.

With these proposed changes, litigants will gain the ability to challenge their experiences of discrimination and provide for relief to empower patients and incite change in healthcare institutions to eliminate the harmful effects of bias.

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## Introduction

*Patient A, a 36-year-old Black woman, decided to take a final trip to visit family before her fast-approaching due date. Because of strict hospital visitation policies related to COVID-19, she wanted to see her loved ones before giving birth. Despite her history of early miscarriages due to lupus, she was overjoyed in knowing she would be a new mom in just one month. She had equal feelings of hope, anxiety, and anticipation for the birth of her first child. While visiting family, she unexpectedly went into early labor and her mother rushed her to the hospital. Both her and her mother were terrified, as she was not expected to deliver for another month. They were concerned for her health as well as the health of the baby. Because she did not have a history of care at this hospital, during her patient intake she was adamant in expressing concern to her providers of her lupus diagnosis when asked of her history of medical conditions, and that she was not due for another month. Because of the early labor, the medical staff quickly assessed the health of the fetus through an ultrasound and determined the heart rate was irregular. She was immediately rushed to the operating room, and the baby was delivered via cesarean section. The baby was taken to the NICU and Patient A remained in the hospital for monitoring. A few hours after the C-section, she called the nurse complaining of chest pain and shortness of breath. Her nurse then relayed this information to the doctor, and the doctor then responded by asking the nurse's opinion of the patient's condition. The nurse replied that the patient had been complaining a lot and proceeded to dismiss her symptoms. Patient A's symptoms continued to worsen, her chest pain grew in severity, and she became drenched in sweat. She was trembling and continued to express her concern to the nurse. The nurse returned to the room and told her that because she had just given birth, she was tired and needed to relax. The nurse quickly left to tend to other patients. Patient A cried in desperation knowing something was wrong, alone in the hospital room and ignored by her providers. A*

*few minutes passed, and she passed out due to lack of oxygen. The medical staff took note of the alarmingly low levels of oxygen in her blood, and soon learned she was suffering from a pulmonary embolism. She was given medication to ease her symptoms, and finally received appropriate treatment for her condition.*

*Patient B, a 24-year-old Black woman, went into labor while at home, and was transported to the hospital via ambulance. She was driven to the nearest hospital because she was so far along in labor, even though she planned to deliver at different hospital due to its reputation for superior care. Her labor progressed quickly, and once she arrived; the hospital staff prepared her for delivery. Because she was alone, had a lack of history of care at the hospital, and was covered by Medicaid, the doctor made assumptions about the reasons for her lack history of care and decided to order a urinary toxicology screening. He assumed that because she was Black and covered by public insurance, she was more likely to use illicit drugs. Without her knowledge or consent, Patient B was tested for drugs. She delivered a healthy boy and expected to quickly return home with him. However, the drug test results were positive for marijuana. Hospital staff prevented her from nursing her son because of these results, and she was devastated that she could not experience this bond with her new baby. The staff then tested her newborn son, and the results were negative. Despite her unconfirmed positive result, the medical staff referred her to child protective services, and they required a home visit. The caseworker traveled to her home and questioned her 9-year-old daughter about her mother's "drug use". She was subsequently investigated and monitored by child protective services due to suspicions of child abuse. She was required to provide her medical records and in addition to contact information for her and her daughter's healthcare providers and her daughter's school. She was told that if she did not comply, she would be subjected to long-term mandatory drug testing. Because of this traumatizing experience, she was reluctant and afraid to continue to seek medical care.*[1]

Although these are not true patient stories, these incidents are not unique or uncommon. Black and brown patients disproportionately experience inadequate and lower quality care due to provider bias, and are drug tested at higher rates than white patients.[2] Patient A should have received proper care

[1] These are not a true patient stories, but inspired by conversations and testimonies from doctors who have witnessed patients suffer due to provider bias.

[2] Hillary Veda Kunins, Eran Bellin, Cynthia Chazotte, Evelyn Du, & Julia Hope Arnsten, *The Effect of Race on Provider Decisions to Test for Illicit Drug Use in the Peripartum Setting*, J Womens Health. (Mar. 2007) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2859171/#:~:text=maternal%20substance%20abuse.-,Results,associated%20with%20a%20positive%20result.

and attention on what should have been a day filled with joy but was instead consumed by panic and fear. The medical staff should have realized she was at a greater risk for a pulmonary embolism during patient intake when she conveyed that she suffered from lupus, and they should have had an even higher suspicion of this condition when she complained of chest pain and shortness of breath, but instead her concerns were dismissed. Due to the presence of antiphospholipid antibodies, individuals with lupus increase complications such as fetal loss or miscarriage, blood clots and pulmonary emboli, in addition to other serious medical conditions[3].

Patient B should not have been tested for drugs, as there was no indication that there was a medical reason requiring testing. In analyzing hospital care, Black women and their newborns are 1.5 times more likely to be tested for illicit drugs as nonblack persons even though there is no difference in drug positivity rates.[4] Leading medical organizations agree that a positive drug test is not an indicator of child abuse or neglect, and drug testing policies are not uniformly administered among patients due to bias and racism.[5] Hospitals often do not have uniform protocols regarding testing and leave it to the discretion of the provider.[6] This practice, known as "test and report", is used as an indicator of child abuse and referral to child protective services.[7] Medical professionals and the foster system target Black and brown patients for drug testing even though there are comparable rates of drug use among people of different races.[8] Additionally, these initial screening tests are extremely sensitive and should be confirmed with more advanced testing methods such as a forensic test.[9] A false positive may even occur when a chemical compound that is present comes from

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[3] *Antiphospholipid Antibodies*, Johns Hopkins Medicine. https://www.hopkinslupus.org/lupus-info/lupus-affects-body/antiphospholipid-antibodies.

[4] *Supra* note 2.

[5] *Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period, The American College of Obstetricians and Gynecologists*. (Dec. 2020). https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period#:~:text=ACOG%20believes%20that%20it%20is,the%20postpartum%20period%20.

[6] *See Id.*

[7] *Id.*

[8] *Id.*

[9] *Clinical Drug Testing of Pregnant Women and Newborns*, National Advocates for Pregnant Women (2019), https://www.pregnancyjusticeus.org/wp-content/uploads/2019/10/NAPW202522Clinical20Drug20Testing20of20Pregnant20Women20and20Newborns-252220March202019.pdf. *See generally* Claudia Lauer, *Mother Sues Hospital Over Drug Test That Led to Abuse Probe*, AP News, (Mar. 11,2020) *https://apnews.com/article/e76d89fc36d9ef-de4b3971cffdcffc89* (Discussing a mother who had a false positive urine test and was reported to child protective services that led to a child abuse investigation).

a lawful source such as medication.[10] Despite no apparent need for intervention, such as the newborn displaying symptoms of withdrawal, there are severe consequences that arise from these referrals to child protective services. Involvement in the child protective system may result in loss of custody, criminal prosecution, and continued surveillance.[11] Beyond the legal consequences, patients may be discouraged from seeking medical care due to fear and distrust.[12]

In each of these patient scenarios, racism impacted the decisions of providers in patient care and treatment because of the discretion given to medical staff in the provision of health care. Medical racism "occurs when the patient's race influences medical professionals' perceptions, treatments and/or diagnostic decisions, placing the patient at risk. Histories of medical experimentation on African Americans show the profound disregard that the medical profession has displayed for Black lives, treating people as 'clinical material'".[13] This medical racism becomes gendered in the medical treatment of Black women, as providers often hold negative beliefs regarding the character and value of the lives of Black women. These ideas are derived from historical narratives of Black women as "superbodies", unworthy of human treatment.[14] Throughout history, Black women and girls have experiences reproductive abuse and exploitation, rooted in the intersection of racial oppression and capitalism[15]. This includes the rape of enslaved Black women as well as medical experimentation. In her book, Deirdre Cooper Owens chronicles the lives of enslaved Black women, examines the proposed justification of medical experimentation on these women, and analyzes the resulting medical racism and common-held beliefs about the patients.[16] She explains, "During the antebellum era, most American doctors believed that Blackness was not only the hue of a person's skin but also a racial category that taught substantive lessons about the biology of race and the so-called immutability of Blackness. Following this biological theory,

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[10] *Id.*

[11] Katharine McCabe, *Criminalization of Care: Drug Testing Pregnant Patients*, American Sociological Association Journal of Health and Social Behavior, 63:2 (Nov. 2021) https://journals.sagepub.com/doi/full/10.1177/00221465211058152#bibr2–00221465211058152

[12] *Supra* note 4.

[13] Dána-Ain Davis, *Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing* Medical Anthropology Vol 38 Issue 7(Dec. 2018) https://www.tandfonline.com/doi/full/10.1080/01459740.2018.1549389.

[14] *See Id.* (defining a medical superbody as "worthy enough for labor and experimentation—such as gynecological experiments to address vesicovaginal fistula—but the woman herself is not worthy of being treated humanely".)

[15] *See Id.*

[16] See generally, Deirdre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology* (2017).

a Black woman could be the same species as a white woman but biologically distinct from and inferior to her."[17] Although racially inferior, the classification of Black women as "superbodies" proved to be a contradiction. Beliefs about Black women's strength were widely published in early medical journals; Black women endured physical violence, performed hard agricultural labor, while enduring childbirth and pregnancy, lending to the belief of physical superiority and higher pain tolerance.[18] Ideological perceptions about womanhood directly conflict with Black women's experiences. The subordination of Black people has denied Black women access to gender norms, such the belief that women are weak or passive.[19] The experimentation on Black enslaved women and their treatment as "clinical material" led to significant advancements in the field of gynecology, specifically surgical procedures such as cesarian sections, obstetrical fistulae repair, and ovariotomies.[20] Black women were deemed worthy of medical care only in the sense that it provided a scientific benefit.

Although the expression of racism has changed over time in medical care, historical beliefs about Black women have continued to impact their care. Racism is currently manifested through diagnostic errors, neglect, disrespect, dismissiveness, abuse, and coercion.[21] Differences in pain perception, stemming from the history of the medical treatment of Black women often lead to inappropriate care, as demonstrated in these patient narratives. Health care providers may "hold false beliefs about biological differences between Black and white individuals that increase implicit bias . . . the presence of these beliefs causes health care providers to rate Black patients' pain lower and results in less appropriate treatment recommendations."[22]

This phenomenon of differential treatment is not specific to Black women in the childbirth setting even though I focus on the experiences of Black women, across care settings, Black patients receive lower quality medical treatment in relation to transplants, cardiac care, cancer care, and amputation as a result of structural racism and bias.

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[17] *Id.* at 2.

[18] *Id.* at 10.

[19] *See* Kimberle Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics, Feminist Theory and Antiracist Politics*. university of chicago legal forum: Vol. 1989 Iss. 1, Article 8. 139, 155–56.

[20] *Supra* note 16 at 5.

[21] See *supra* note 13.

[22] Bani Saluja & Zenobia Bryant, *How Implicit Bias Contributes to Racial Disparities in Maternal Morbidity and Mortality in the United States*, Journal of Women's Health Vol. 30 No 2. (2 Feb 2021) *https://www.liebertpub.com/doi/10.1089/jwh.2020.8874.*

Racism is foundational to society, deeply impacts the health experiences and outcomes of Black patients, and is essentially a civil rights issue. Because antidiscrimination laws were precisely created to address the impact of subordination, this legal tool should be used to challenge it. The specific intent of Congress in enacting the Civil Rights Act of 1964 was to prevent discrimination and promote equality. Historically, it has been proven to be an essential tool to combat discrimination in employment, education, housing, public accommodations, and voting.[23] The realization of civil rights in society necessitates equal access to care, independent of a patient's identity. However, due to the continued effects of racism and discrimination, this has yet to be achieved. This paper will proceed in four parts. First, I will present the framework within which racial health disparities are perpetuated and explain how racism within healthcare is shaped by conceptions of race. In Part II, I argue that although advocates for patients who experience racism in health care may litigate disparate treatment claims and possible disparate impact claims under Section 1557 of the Affordable Care Act, current civil rights doctrine does not provide a remedy for the full range of harms caused by racial discrimination in health care, and the existing civil rights framework must be amended. Prior cases in health and employment provide insight into how these claims may proceed. In Part II, I present a new framework to address these gaps in the current legal doctrine. Finally, in Part III, I explain the shortfalls and impediments to this proposed framework in addition to other possible avenues to challenge these disparities including legislation and policy efforts.

## I. Framework: Bias, Structural Racism, and the Civil Rights of Health

### A. *Bias, Structural Racism and Intersectionality in Health Care*

In order to challenge racism in society, it must be recognized as a ubiquitous phenomenon that influences all individuals' beliefs and behaviors. "Racism is viewed as a dynamic societal system that is shaped by and reshapes other social institutions such as the political, legal, and economic systems. Central to racism, in the US context, is a hierarchical ideology that the dominant white group uses to categorize and rank social groups into races with whites being superior compared to other races."[24] Racism operates to create inequity through cultural

[23] Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*. December 13, 2020. 67 UCLA L. REV. 758, 783 (2020).

[24] David R. Williams, Jourdyn A. Lawrence, Brigette A. Davis & Cecilia Vu, *Understanding how discrimination can affect health*. Health Serv Res. (Oct. 29, 2019); 54: 1374– 1388. https://doi.org/10.1111/1475–6773.13222

racism, structural racism, and individual discrimination.[25] Cultural racism establishes the belief in the inferior status of Blacks and other racial and ethnic minority groups in society and cultural norms that result in the persistence of negative beliefs and attitudes that devalue, oppress and subordinate nonwhites.[26] Cultural racism enables biases that contribute to the restriction of resources such as medical care for marginalized populations.[27] Structural racism "develops and sustains policies and structures that empower the dominant group to differentially allocate desirable societal opportunities and resources to racial groups regarded as inferior."[28] Lastly, individual discrimination is the negative differential treatment that stigmatized racial groups receive from individuals and social institutions, which lead to reduced access to resources and opportunities.[29] These various forms of racism impact the condition and well-being of Black people as well as other racial and ethnic minority groups.

A Critical Race Theory framework provides an understanding of how racism and racial subordination are rooted in the foundation of our legal system and are maintained through current policies and practices. Despite progress in racial equality through civil rights laws, racism and subordination have persisted, and their impact is visible particularly in racial health disparities. Critical Race Theory allows for the examination of how bias and structural racism contribute to adverse health outcomes. An intersectional approach to addressing these issues recognizes that multiple identities are implicated in this examination. Mari J. Matsuda argues that in determining how to understand the way the legal system impacts oppressed communities; we must look to the perspective of those experiencing that oppression.[30] She explains that individuals who are experiencing oppression are in the best position to tell us how it is working in their lives to create solutions to challenge it.[31] In analyzing racism in health care and its impact on Black patients receiving maternal care, it is necessary to learn from the actual experiences of the Black community, and Black women specifically, facing discrimination in healthcare institutions in order to understand how the law is serving as a tool of subordination and inflicting harm. Angela P. Harris, a critical race feminist, argues the importance of "multiple consciousness" in legal discourse, which allows for the examination of legal issues and rights in the

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[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] Mari J. Matsuda, *Looking to the Bottom: Critical Legal Studies and Reparations*, 22 harv. c.r.-c.l. l. rev. 323 (1987).
[31] *Id.*

abstract aspirational lens and the use of knowledge in how these issues impact real people's lives.[32] Chandra Ford and Collins Airhihenbuwa introduced the Public Health Critical Race praxis, which facilitates the use of Critical Race Theory in health equity research by enabling the understanding of the prominence of racialization in society and in one's personal life and promoting race consciousness in conducting research.[33] In this article, I hope to examine racism in health care using the voices of experience and theory.

Although I argue for the reform of legal doctrine, I also recognize the legal system as it exists today is inherently flawed and will not allow for true justice and equality. Racism is built into the fabric of our legal system and works to maintain social hierarchy, and still plays a role in continued racial subordination. In her article describing structural racism as the root cause of health disparities, Ruqaiijah Yearby explains, "Structural racism is the way our systems (health care, education, employment, housing, and public health) are structured to advantage the majority and disadvantage racial and ethnic minorities."[34] The configuration of these systems has led to differential opportunities, resources, and well-being among racial and ethnic groups resulting in health disparities.[35] The law has organized these systems in an inequitable and discriminatory manner that reinforces discriminatory beliefs and values.[36] Currently, the legal system does not provide a mechanism to challenge structural racism because antidiscrimination law necessitates the identification of a specific individual or policy that causes harm rather than recognizing the pervasive racism built into our institutions and society as a whole.

In examining the experiences of Black women in the medical system, one must also recognize the intersection of race and gender. However, current discrimination doctrine requires us to identify only one specific protected category to which a party belongs. Kimberle Crenshaw, a leading scholar in Critical Race theory argues, "if any real efforts are to be made to free Black people of the constraints and conditions that characterize racial subordination, then theories and strategies purporting to reflect the Black community's needs must include an

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[32] Angela P. Harris, *Race and Essentialism in Feminist Legal Theory*, Stanford Law Review, Vol. 42, No. 3 581, 584 (Feb. 1990).

[33] Chandra L. Ford, Collins O. Airhihenbuwa, *The public health critical race methodology: praxis for antiracism research*, Social Science and Medicine, Vol 71 Issue 1 1390–98, (Oct. 2010), https://doi.org/10.1016/j.socscimed.2010.07.030.

[34] Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause*. The Journal of Law, Medicine & Ethics, 48(3), 518–526. (Oct. 6, 2020) https://doi.org/10.1177/1073110520958876.

[35] *Id.*

[36] *Id.*

analysis of sexism and patriarchy."[37] Black women often face double-discrimination, which is the convergence of race and sex discrimination.[38] Intersectionality "examines how multiple oppressed identities interact to crate overlapping and compounding systems of disadvantage."[39] This is particularly relevant in health care, as there are specific stereotypes about Black women and reproduction. She notes, "dominant conceptions of discrimination condition us to think about subordination as disadvantage occurring along a single categorical axis."[40] She argues that in limiting the analysis of discrimination to one singular axis, it erases "Black women in the conceptualization, identification and remediation of race and sex discrimination by limiting inquiry to the experiences of otherwise-privileged members of the group."[41] When specifically looking at discrimination in health care, Black women must face the compounded effects of race and gender biases and stereotypes, and are subordinated in a way that is different from others in the same race and gender category, that being Black men and white women. In forcing this choice, it limits the ability to examine the role of patriarchy in creating the health disparities of Black women. Antidiscrimination doctrine as it stands "forces [Black women] to choose between specifically articulating the intersectional aspects of their subordination."[42] In choosing to only look at race discrimination or sex discrimination, it obfuscates the specific and unique experiences of Black women. Black feminist scholarship asserts that "at the intersection of race and gender, Black women have specific experiences that are unique to being both 'Black' and 'woman.'"[43] Gendered racism is exemplified by biases about Black women having higher pain tolerances in addition to stereotypes about Black mothers, with terms such as "welfare queens."[44] Patient A faced substandard care due to provider bias when her pain was ignored, and Patient B suffered the consequences of assumptions about her competence as a mother and caregiver. Although the current civil rights framework does not

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[37] Kimberle Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics, Feminist Theory and Antiracist Politics*. University of Chicago Legal Forum: Vol. 1989 Iss. 1, Article 8., 166.

[38] *Id.* at 149.

[39] *Intersectionality Self-Study Guide*, Washington University in St. Louis, https://students.wustl.edu/intersectionality-self-study-guide.

[40] *Supra* note 31 at 140.

[41] *Id.*

[42] *Id.* at 148.

[43] Mia Brantley, *Black feminist theory in maternal health research: a review of concepts and future directions*, Sociology Compass, Vol 17 Issue 5 (Feb. 27, 2023). https://compass.onlinelibrary.wiley.com/doi/full/10.1111/soc4.13083

[44] *Id.*

incorporate intersectionality, it is critical to understand how Black women face particularized harm in the medical setting.

The specific stereotypes about Black patients stem from generalized ideas about individuals grouped in this racial category without accounting for other individual characteristics, impacting the care they receive. Essentialism is the notion that a unitary experience "can be isolated to and described independently of race, class, sexual orientation, and other realities of experience."[45] Essentialism may lead to stereotyping and biases against individuals perceived to be members of the same social group.[46] Research has shown that "essentialism leads people to believe that social categories reflect objective structure in nature, and thus that observed social hierarchies reflect objective differences in status or value."[47] Because of the existing racial hierarchy in our society, essentialism results in Black patients receiving a lesser quality of care as they are believed to be of lower status and lesser value. Furthermore, implicit bias is the "unconscious tendency to perceive or act according to cultural stereotypes about social groups, whether those stereotypes are benign or malign."[48] These stereotypes stem from cultural and societal influences that shape our beliefs of people we categorize into different racial groups. Charles Lawrence, a Critical Race scholar, explains that racism has specifically shaped our culture and history in the US, resulting in common ideas, attitudes, and beliefs about racial groups.[49] Because of this common culture, we all share discriminatory beliefs and ideas that produce behavior motivated by unconscious racism.[50] In illustrating how implicit bias affects patient care, Matthew explains, "the physician is likely to rely upon his stored background knowledge to tell him what he does not know about this patient . . . Unintentionally, this doctor is likely to make statistical judgements about the medical data he receives about this Black patient that are different from than the judgements and conclusions he would reach based on the same data about a white patient."[51] These judgements will lead to different quality of care and the patient's health outcomes.[52] Although implicit bias is

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[45] *Supra* note 32 at 585.

[46] Mandalaywala, T. M., Amodio, D. M., & Rhodes, M. (2018). Essentialism Promotes Racial Prejudice by Increasing Endorsement of Social Hierarchies. *Social Psychological and Personality Science*, *9*(4), 461–469. *https://doi.org/10.1177/1948550617707020*.

[47] *Id.*

[48] *Supra* note 23 at 784–785.

[49] See Charles R. Lawrence III, *The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism*, stan. l. rev. 317, 322 (1987).

[50] *Id.*

[51] Dayna Bowen Matthew, *Just Medicine: A Cure for Racial Inequality in American Health care*, New York University Press (2015) 50.

[52] *Id.*

frequently conceptualized as an individual issue, society has a collective responsibility in the cause and elimination of these biases that uphold white supremacy. Generally, discrimination has centered on individual intent rather than implicit bias, however implicit bias is nonintentional.[53] This is demonstrated throughout the narrative. One example of implicit bias is the use of negative descriptors in patient health records.[54] Research shows that Black patients are 2.5 times more likely to have a negative descriptor in health records such as aggressive, combative, exaggerate, combative, and agitated.[55] These descriptors reinforce biases and stereotypes, and may impact the assessments and treatment decisions of other members of that patient's care team, even if they do not hold those biases.[56] In the first narrative, the nurse's biases impacted the treatment patient A received, as she relayed her presumptions and the exaggeration of her pain to the doctor. As stated by Lawrence, racism is a societal disease that "commands our collective responsibility for its cure."[57] This disease has perpetuated its harm through the racial power structure and concrete effects of racial subordination that are reinforced by ideology that justifies the injury.[58] This harm occurs even without intent or a specific offender because racism is so deeply engrained in our society and outside the boundaries of our awareness.[59] Interest theory views ideology as a weapon to rationalize and reinforce subordination by the dominant group to maintain power "by institutionalizing a particular view of reality."[60] Racism has explicitly been incorporated in our legal system and racist ideology has been used to preserve white supremacy, leading to health disparities among those deemed to be nonwhite.

B. *Civil Rights of Health*

The civil rights of health framework, presented by Angela P. Harris, a legal scholar in the field of critical race theory and feminist legal theory, and Aysha Pamukcu, an attorney working in public health and social justice advocacy,

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[53] *Supra* note 23 at 784.

[54] Michael Sun, Tomasz Oliwa, Monica E. Peek, & Elizabeth L. Tung, *Documenting Racial Bias in the Electronic Health Record*, Health Affairs Vol. 41 No. 2 (19 Jan 2022) https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01423?utm_term=sun&utm_campaign=february2022issue&utm_medium=press&utm_content=ahead+of+print&utm_source=mediaadvisory.

[55] *Id.*

[56] *Id.*

[57] Charles R. Lawrence III, *Unconscious Racism Revisited: Reflections on the Impact and Origins of "The Id, the Ego, and Equal Protection"*. 40 CONNECTICUT L. REV. 931–978, 942 (2008).

[58] See *Id.* at 943.

[59] See *Id.* at 948.

[60] *Supra* note 49 at 326.

illustrates that the persistence of health disparities is linked to "subordination on the basis of race, gender, class, citizenship, sexuality, and other power and privilege differentials."[61] They argue health is "deeply influenced by institutional and structural forces that shape who has access to the opportunities and resources needed to thrive."[62] As critical race theory allows us to understand how our legal system is rooted in subordination and how this is sustained through policies and practices, the civil rights of health framework explains how this subordination results in health disparities. The specific pathways through which subordination produces health disparities are population, place, and access to power.[63] Harris and Pamukcu articulate the health effects of subordination, and how the framework may be used as a tool for advocacy around the reduction or elimination of unjust health disparities.[64] Health disparities are linked to "social, economic, and or environmental disadvantage because they result from historic and ongoing injustices against stigmatized or vulnerable groups."[65] These differential health outcomes are seen among various marginalized groups that are impacted by subordination, although this paper will focus specifically on Black mothers. When examining the disparities in the health outcomes of Black mothers, "an important cause is gendered racial discrimination, including toxic stress on Black mothers from interpersonal discrimination in daily life, institutional discrimination in the provision of health care, medical research that prioritizes white male bodies, and even transgenerational biological transmission of the effects of discrimination."[66] This framework calls for "(1) eliminating discrimination against stigmatized groups; (2) changing the spatial distribution of healthy environments, economic resources, and opportunity; and (3) equally distributing the power to affect the conditions of one's life."[67] This paper will address the first and third components by advocating for a new doctrinal framework to address implicit bias in healthcare. Provider discrimination in the health care system results in inadequate care and restricts a patient's personal agency resulting in disempowerment. "Power-to" is defined as control over one's destiny and is recognized as a key social determinant of health that contributes to the risk of chronic disease and mental illness.[68] One component of power-to is the ability

[61] *Supra* note 23 at 770.
[62] *Id.* at 762.
[63] Id at 770.
[64] See generally *Id.*
[65] *Id.*
[66] *Id.* at 772–73.
[67] *Id.* at 764.
[68] *Id.* at 778.

to exercise control over one's environment to fulfill the need for safety.[69] They explain, "The major pathways through which health disparities travel-population, place, and power-can all be traced back to historic and continuing patterns of exploiting or marginalizing some communities for the benefit of others."[70] These pathways originate in subordination, and the legal system may be used as a tool dismantle it.[71] Although there are other societal and structural forces that result in disparate health outcomes for marginalized populations, bias in the provision of care must be challenged to incite change in healthcare institutions and aid in eliminating racial health disparities.

## II. Doctrinal Question: Are Claims Arising from Structural Racism and Implicit Bias Cognizable under Section 1557?

Although advocates for patients who wish to challenge their experience of racism in health care can litigate disparate treatment and possible disparate impact claims under section 1557 of the Affordable Care Act as the current administration may allow for private action, these mechanisms do not provide a remedy for the full range of harms caused by racial discrimination in health care, specifically implicit bias. The current structure of civil rights statutes is insufficient to confront implicit bias. Despite widespread hope of private action to challenge disparate impact under section 1557, this will be ineffective in addressing implicit bias. Beyond permitting private action, I argue that the disparate impact framework must shift to a new doctrinal test. This expansion will allow litigants to challenge implicit bias.

### A. *The Progression of Civil Rights Litigation in Health Care*

Reviewing how racial discrimination has previously been litigated within the civil rights framework will provide an understanding of the ways it has been effective, what specifically it has been successful in challenging, in addition to giving insight into how it must change moving forward. The passage of the Civil Rights Act of 1964 provided hope against the backdrop of widespread racial discrimination and was celebrated as a victory in finally guaranteeing equality. More specifically, Title VI and Title VII were recognized as protecting individuals from the harms of racist practices in employment and discrimination under programs or activities receiving federal funds.[72] Title VI states, "No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected

[69] *Id.* at 779.
[70] *Id.* at 783.
[71] *Id.*
[72] 42 U.S.C.A. § 2000d (West).

to discrimination under any program or activity receiving federal financial assistance."[73] Because most healthcare institutions receive federal funds, this legislation has a wide-ranging reach. The Civil Rights Act was effective in desegregating health care facilities, whether that be among patients or staff.[74] However, the conceptions of the manifestation of racism are based upon the harm done by individuals rather than society, requiring the identification of a particular culprit. Through a disparate impact claim, the plaintiff may challenge a facially neutral policy or practice that has a disproportionately adverse impact on a protected class.[75] With a disparate treatment claim, the plaintiff is required to prove intentional discriminatory action.[76]

Disparate treatment has not been used often to combat discrimination in healthcare. Historically, disparate impact claims have proven to be somewhat effective in challenging explicit discrimination in the healthcare setting, including policies that effectuated segregation among patients and in provider hiring practices following the passage of the Civil Rights Act of 1964. These claims have been brought forth through Title VI of the Civil Rights Act of 1964, which prohibits discrimination under any program or activity receiving federal funds.[77] Sections 601 and 602 of the Civil Rights Act of 1964 prohibit the allocation and distribution of federal funds in a discriminatory manner. Section 601 relates to intentional discriminatory policies or disparate treatment claims, while section 602 applies to policies that are facially neutral but have an unintended discriminatory impact or disparate impact claim. With a disparate treatment claim, the plaintiff must prove the discrimination was intentional. *Griggs v. Duke Power Co.* was the first case considered by the United States Supreme Court based on disparate impact.[78] The Court asserted that the Civil Rights Act "proscribes not only overt discrimination but also practices that are fair in form, but discriminatory in operation."[79] Proving a violation of Title VI through a disparate impact theory includes a three-part test that asks if the adverse impact of the policy or practice affects a protected class, if there is there a legitimate justification for this policy or practice, and if this justification is pretextual.[80] Lastly, it asks if an

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[73] 42 U.S.C.A. § 2000d (West).

[74] Dayna Bowen Matthew, *A new Strategy to Combat Racial Inequality in American Health Care Delivery*, DEPAUL JOURNAL OF HEALTH CARE LAW, Vol. 9:1 798, 806.

[75] *Id.* at 24.

[76] *Id.*

[77] 42 U.S.C.A. § 2000d (West).

[78] *Griggs v. Duke Power Co.*, 401 U.S. 424 (1971).

[79] Id at 431.

[80] The US Department of Justice *https://www.justice.gov/crt/fcs/T6Manual7#C*, NY Urban League v. State of New York 71 F.3d 1031 (2d Cir. 1995).

alternative policy achieve the same legitimate objective with a less discriminatory effect that does not violate disparate impact regulations.[81] With a disparate impact claim, there is no need to prove intent, rather the plaintiff may use statistical evidence that a policy or practice has a discriminatory impact to make its prima facie case of discrimination.[82]

There have been various cases related to health care that initiated disparate impact claims via Title VI since its enactment. These cases challenged discrimination in policies impacting minority health providers, segregation within health care facilities, as well as separate and unequal services within health systems.[83] The case of *Linton v. Comm'r of Health and Environment of Tennessee* was a class action brought in 1995 by minority plaintiffs eligible for Medicaid, which challenged the bed certification policy used by Tennessee nursing homes.[84] This policy allowed nursing homes to identify certain beds for Medicaid participation while other beds were for private-pay patients. The Tennessee District Court found this policy to be in violation of Title VI, as the program has a disparate and adverse impact on minorities that were more likely to be impoverished and have Medicaid coverage, and therefore more likely to be excluded from care.[85] This case identifies a specific policy that has a disparate impact on minority patients and provides clear statistical evidence in addition to stories from patients who suffered as a result of this policy to prove their claim.[86] Demonstrated by this case, three essential components of Title VI cases include, "the 1) precisely targeted allegations of disparate impact; 2) supported by statistical evidence of the disparate impact alleged; and 3) demonstrated by detriment suffered in the lives of real people who are part of the plaintiff class.[87] Statistical evidence that a practice or policy has had a disproportionately negative discriminatory impact was generally used to prove a disparate impact claim.[88] Then, the defendant had to show legitimate goal is served by the alleged discriminatory practice.[89]

The role of racism in causing health disparities is complex, comprising of structural as well as interpersonal discrimination. My argument centers on shifting the framework to target implicit bias in care delivery using Title VI, however,

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[81] https://www.justice.gov/crt/fcs/T6Manual7#C.
[82] *Supra* note 74 at 807.
[83] *Supra* note 35 at 25.
[84] *Supra* note 74 at 812.
[85] *Id.*
[86] *Id.* at 813.
[87] *Id.* at 814.
[88] *Id.*
[89] Id at 807.

the statute has also been used to challenge structural discrimination. Although generally unsuccessful, Title VI has also been used to challenge hospital closures and relocations that disproportionately impact minority patients.[90] Generally, courts have been deferential to the business-related explanations for relocation and have found relocations to be justifiable regardless of the disparate impact.[91]

The case of *Ferguson v. City of Charleston*, is a more recent case that involved a private action alleging a Title VI violation, although proving that claim was ultimately unsuccessful.[92] In *Ferguson*, the plaintiffs claimed "testing for and reporting of cocaine use by pregnant women disparately impacted African American women."[93] This claim was unsuccessful because the plaintiffs did not provide an alternative to accomplish the goals of the policy in addressing cocaine use by pregnant women that did not pose undue costs and burdens on the hospital and impose a less disparate impact on African Americans.[94] Even with the allowance of private action and data to prove disparate impact, the Title VI claim proved to be ineffective. In examining drug testing of birthing patients, there is often no specific policy to point to, but rather it is left to the discretion of the physician in determining who to test, which provides room for implicit bias to influence provider decisions. Factors that may influence a provider's decision to do a toxicology screen include race, single marital status, preterm labor, and previous prenatal care.[95] The use of these particular factors in determining whether to screen a patient demonstrate how providers' personal attitudes and biases may impact their patient assessment and care decisions, as these factors are often unrelated to drug use and target minority populations that are more likely to qualify.[96] Because the decision to test Patient B for drugs was left to the discretion of the doctor, the doctor's biases led to unnecessary testing when considering her insurance status and history of care. If Patient B were to file a discrimination claim, there would be no policy or practice she could identify in the lawsuit that resulted in her unequal treatment. Not only is it hard to point

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[90] *Id.* at 817.

[91] *Id.* at 817–818. (Discussing cases where plaintiffs have challenged the disparate impact of hospital relocation).

[92] *Ferguson v. City of Charleston, S.C.*, 186 F.3d 469, 479 (4th Cir. 1999).

[93] *Id.*

[94] Andrew J. Kornblau, *Racial Injustice? Ferguson v. City of Charleston and the State of Title VI in the Post-Sandoval Era*, Rutgers Journal of Law and Urban Policy 2 Rutgers J.L. & Ur, Vol.

2:2 (May 2005) 353, 368.

[95] Bonnie D Kerker, Sarah M. Horowitz, John M. Leventhal, *Patients' characteristics and providers' attitudes; predictors of screening pregnant women for illicit substance use*, https://www.sciencedirect.com/science/article/pii/S0145213404000092

[96] See *Id.*

to a specific policy or practice, even when plaintiffs are able to identify one, the balancing test often tilts in favor of the defendant when the plaintiff is required to present an alternative policy that achieves the same legitimate objective.

B. *Employment Litigation as an Analogy*

Because disparate impact requires the identification of a policy or practice, litigation has rarely been used to challenge implicit bias in healthcare delivery. Although there are no cases in health care that have challenged implicit bias, this issue has been considered in the employment context. Looking to the employment context is value because it allows for the comparison of how similar principles may apply in health care. Litigation in employment law has provided some examples of the strategies plaintiffs have used to challenge implicit bias using a disparate impact claim. Similar to Title VI, Title VII claims include disparate impact and disparate treatment theories of liability.[97] Disparate impact theory requires the plaintiff to show employment practices have a disparate impact on a protected group, and the burden then shifts to the defendant to prove the practices are "job-related and justified by business necessity."[98] In *Wal-Mart Stores, Inc. v. Dukes*, the plaintiffs, 1.5 million current and former Wal-Mart employees, brought a Title VII class action claim against the company because of discrimination against women.[99] The plaintiffs alleged that in exercising their discretion over pay and promotions, local managers favored men, which had a disproportionate impact on female employees.[100] The court recognized pay and promotion decisions are determined subjectively by local managers.[101] This cased is based on the theory that corporate culture allows for bias against women and gender stereotypes to impact the decisions of managers.[102] The Court stated the only policy the plaintiffs establish is "allowing discretion by local supervisors over employment matters," and went on to say, "on its face, of course, that is just the opposite of a uniform employment practice that would provide the commonality needed for a class action; it is a policy against having uniform employment practices."[103] It asserted that this business practice should not raise an inference of discriminatory conduct.[104] In

[97] 42 U.S.C.A. § 2000e (West)

[98] Tristin K. Green, *Discrimination in Workplace Dynamics: Toward a Structural Account of Disparate Treatment Theory*, 38 HARV. C.R.-C.L. L. REV. 91, 136 (2003).

[99] *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338 (2011)

[100] Id at 341.

[101] *Id.* at 343.

[102] *Id.* at 345.

[103] *Id.* at 355.

[104] *Id.*

this case, the plaintiffs were unable to identify a particular policy or practice with a disparate impact despite substantial evidence of gender discrimination. The Court concluded, "other than the bare existence of delegated discretion, respondents have identified no 'specific employment practice' . . . merely showing that Wal-Mart's policy of discretion has produced an overall sex-based disparity does not suffice."[105] In this case, the lack of a uniform policy results in widespread discrimination due to bias. This scenario relates to the narrative presented about Patient B, as the decision to drug test was left to the discretion of the provider and resulted in discrimination. In the concurrence in part, Justice Ginsburg asserted "the practice of delegating to supervisors large discretion to make personnel decisions, uncontrolled by formal standards, has long been known to have the potential to produce disparate effects,"[106] and stated "aware of the problem of subconscious stereotypes and prejudices, we held that the employer's undisciplined system of subjective decisionmaking was an employment practice that may be analyzed under the disparate impact approach."[107] With no policy in place to determine when to drug test patients, subjective-decision-making provides room for provider bias to come it and impact patient care. Ginsburg refers to *Watson v. Fort Worth Bank & Trust* and *Wards Cove Packing co. v. Atonio* where subjective decision-making in employment was challenged under a disparate impact theory.[108] Ginsburg argued the allowance of uniform discretion is a policy, and this system of discretion is actionable when the effect is discriminatory outcomes according to *Watson*.[109] Finally, she noted the statistical evidence presented by the plaintiff's expert witness was sufficient to give rise to an inference of discrimination.[110] Similar to the operation of bias in employment practices, subjective decision-making and systems of discretion in healthcare leads to disparities and disproportionate health outcomes for minority patients. Without policies in place that limit bias, discrimination remains pervasive and results in health and employment-related disparities.

In *Pippen v. State*, a group of Black plaintiffs brought a class action suit alleging disparate impact due to discrimination in hiring by the state of Iowa.[111] They claimed the state engaged in practices that denied a disproportionate number of Black applicants an opportunity for employment in addition

[105] *Id.* at 357.

[106] Walmart concurrence in part 372.

[107] Concurrence in part 374.

[108] *Watson v. Ft. Worth Bank and Tr.*, 487 U.S. 977 (1988), *Wards Cove Packing Co., Inc. v. Atonio*, 490 U.S. 642. (1989).

[109] Walmart concurrence 377.

[110] Walmart concurrence 372.

[111] *Pippen v. State*, 854 N.W.2d 1, 4 (Iowa 2014).

to systemic racial bias.[112] Using statistical evidence, expert testimony revealed, "African Americans were treated differently and more disadvantageously than whites with respect to the referral of applications by DAS for interviews, and with respect to ultimate hiring."[113] The plaintiffs also offered the testimony of two psychology professors that described the impact of implicit bias on the state's hiring process, and offered studies regarding the effects of stereotyping and prejudice on decision-making.[114] The court recognized that bias contributes to the inequality that the Civil Rights Act was designed to address and stated, "The legacy of slavery and Jim Crow may be in the past, but their effects cast a shadow into the present."[115] Despite this recognition, the court affirmed the decision of the district court in concluding the plaintiffs failed to identify a specific employment practice alleging the state's failure to adhere to its regulatory responsibilities of its employment system, and failed to prove the causation element of their disparate impact claim.[116] This case provides another example of how the inability of the plaintiff to identify a policy or practice resulting in disparate impact causes the claim to fail. Additionally, the defendant's failure to address implicit bias through discretion in decision-making results in discrimination. In the narratives of Patient A and Patient B, there is no specific policy or practice they may point to in asserting a disparate impact claim. The only causation the patients can point to is the discretion of the medical providers and the influence of their biases on care.

Although the purpose of Title VI is to prevent discrimination, its enforcement has been limited. Because of the Supreme Court ruling in *Alexander v. Sandoval*, where the Supreme Court ruled there is no private right of action, policies resulting in a disparate impact may only be enforced through public means.[117] This has left enforcement of these claims up to the government through Title VI investigations conducted by the United States Department of Health and Human Services. Since this ruling, there has been a significant decrease in litigation to enforce Title VI.[118] Despite the *Sandoval* ruling, there has been hope that Section 1557 of the Affordable Care Act will allow for a private right of action to challenge disparate impact in healthcare. Section 1557 mirrors the Civil Rights Act of 1964 in stating "an individual shall not on the ground prohibited under

[112] Id at 5.
[113] Id at 6.
[114] *Id.*
[115] *Id.* at 8.
[116] *Id.*
[117] See *Alexander v. Sandoval*, 532 U.S. 275 (2001).
[118] *Supra* note 35 at 28.

title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance."[119] The enforcement mechanisms of title VI, title IX, section 504, or the Age Discrimination Act apply to violations.[120] Even with the possibility for private action, the manifestation of discrimination in health care has evolved since the passage of title VI, so this proposed solution is nevertheless inadequate.

### C. *Existing Legal Frameworks for Civil Rights Claims are Insufficient to Counteract Bias*

The Supreme Court has continuously held that Title VI prohibits practices that have a "discriminatory effect on protected groups, even if the actions or practices are not intentionally discriminatory."[121] This demonstrates an objective of contesting the effects of racism. Although implicit bias does not fit within the traditional framework, it is clear the intent behind the statute is to target the effects of discrimination, even when it may be unintentional such as through implicit bias.

In the context of health and employment, the nature and manifestation of racism has changed. Currently, racism causes most harm structurally and implicitly, therefore is often invisible and unnoticed. For example, changes in employment practices, such as the increase in the decentralization and subjectivity of work performance evaluation, have made room for implicit bias to perpetuate inequity on the basis of race or sex.[122] Without specific criteria for evaluations, decisions may be influenced by biases.[123] There are various issues with the existing civil rights framework to address discrimination. Disparate treatment theory requires the plaintiff to show an intentional or conscious motivation to discriminate, which is not the most prevalent way discrimination causes harm. Because the harm caused by implicit bias is unintentional, disparate treatment theory is unsuitable. Although disparate impact does not require the demonstration of intent, it is still insufficient. First, it requires the plaintiff to point to a specific policy or practice and there is often no policy that accounts for the disparate treatment of minority patients but rather the lack of

[119] 42 U.S.C.A. § 18116 (West).

[120] 42 U.S.C.A. § 18116 (West).

[121] https://www.justice.gov/crt/fcs/T6Manual7#C.

[122] Tristin K. Green, *Discrimination in Workplace Dynamics: Toward a Structural Account of Disparate Treatment Theory*, 38 HARV. C.R.-C.L. L. REV. 91, 99–103 (2003).

[123] Id at 107.

a policy that requires uniformity in practices. For instance, with hospital drug testing, it is often left to the discretion of the provider to order testing, which may be influenced by biases and stereotypes they hold about the patient, demonstrated by the narrative of Patient B. Second, the current framework places too heavy a burden on the plaintiff to prove discrimination rather than presuming bias. Looking to the narratives of Patient A and Patient B, there is no specific policy or practice they can point to that was the cause of their discriminatory treatment. Both scenarios display how provider discretion allows for the operation of implicit bias. Because of the deeply entrenched racism in the healthcare system and power imbalance between the plaintiff and defendant, the current framework is inadequate and unjust. The defendant often has more financial resources and access to power. Because bias is so universal, it should be the obligation of the institution to address discrimination. The lack of policies that prevent and minimize the operation of implicit bias allows for the preservation of inequity.

D. *Proposed Reforms*

After analyzing the current legal framework to challenge discrimination in healthcare, it is evident these methods would not allow for the confrontation of implicit bias and redress the harms many patients face, particularly those who identify as Black women, in the health care setting. For these reasons, I propose a new framework that would allow patients, such as Patient A and Patient B, to litigate the racism they face by medical providers. Even though the new proposed framework is presented using the narratives of Black mothers, it may also be used to challenge implicit biased faced by other marginalized populations that experience health disparities as a result of subordination and face bias in health care. Although there is no private right of action for a disparate impact claim under Title VI, there is possible private action under Section 1557 of the ACA. However even with private action, the enforcement of the nondiscrimination requirement is based upon the mechanism provided for and available under Title VI of the Civil Rights Act of 1964.[124] So, plaintiffs must still use this framework to prove claims of discrimination. In her book on racial inequality in health care, Dayna Bowen Matthew, a scholar in public health and civil rights law, proposes to amend Section 601 language to address implicit bias in policies or practices by restoring private action and adding a negligence-based claim that requires the defendant to demonstrate "it has taken reasonable steps to reduce discriminatory harms due to unconscious or unintentional biases" after

[124] Titlt 45, Subtitle A, Subchapter A, Part 92. National Archives Code of Federal Regulations, https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-92.

the plaintiff has identified a policy or practice that has caused a disparate impact on the basis of race, color, or national origin, and that policy or practice is not reasonably related to a nondiscriminatory goal of the program or activity, or the plaintiff demonstrates a less discriminatory policy or practice exists that the entity failed to adopt.[125] However, I propose this change go even further as it is often difficult to point to a specific program or activity that results in a disparate impact. I propose that 1) the plaintiff must establish that the entity is subject to the title and experienced a disparate outcome caused by that entity. The courts should then automatically assume the presence of discrimination due to the disparate outcome, and the burden then shifts to the defendant. 2) the defendant must show the disparate impact was not a result of discrimination, and 3) that it has taken reasonable steps to reduce discrimination due to structure or practices that may be a result of bias. This proposed change removes the need to identify a specific discriminatory policy or practice and acknowledges the pervasiveness of bias.

Using the new framework to establish the plaintiff experienced a disparate outcome, specific accounts as well as statistical evidence of patient outcomes may be presented. Similar to the narrative of Patient A, additional accounts of Black women receiving inadequate care at a specific health care facility may be introduced to demonstrate adverse health outcomes for patients identified to be members of their protected class. This new framework does not require the plaintiff to point to a specific policy or practice that resulted in the disparate impact, however, the plaintiff may point to how a lack of uniformity in care in addition to the lack of standard procedures and protocols allow for implicit bias to operate. With claims initiated by Patient A and Patient B, they may prove their disparate outcome, inadequate care and unnecessary and nonconsensual drug testing leading to monitoring by child protective services, and the court would automatically conclude this occurred as a result of bias. The patients may then assert that the lack of physician guidelines and protocols that provided room for implicit bias due to provider discretion. The plaintiffs may also use expert testimony to describe the impact of implicit bias on the decisions of health care providers. The healthcare institutions would likely have difficulty in demonstrating the disparate impact was not a result of discrimination and that it has taken reasonable steps to reduce bias given the lack of protocols and guidelines. This new framework would assist in allowing for more patients to challenge discrimination in health care and promote change in institutions to address the presence of bias. By assuming the existence of bias, the burden is

[125] *Supra* note 51 at 210.

placed on health care institutions to address racism. The presumption would prompt entities to actively take steps to reduce the effects of implicit bias and determine where bias is influencing patient outcomes.

E. *Remedies Resulting from New Framework*

Once a court has determined the plaintiff was successful in presenting their disparate impact claim, the court must determine the remedies available to the plaintiff. Courts would look to the language of section 1557 to determine the remedies for patients who prove disparate impact in a health care institution. Section 1557 states "[t]he enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection."[593] Additionally, this provision is consistent with the 2016 Rule at former § 92.301(a) and § 92.5(a) of the 2020 Rule. Enforcement mechanisms include a private right of action, as recognized by the Supreme Court in *Cummings v. Premier Rehab Keller, P.L.L.C.*"[126] Currently, the statutory text does not explicitly state the availability of relief for emotional harm or punitive damages, but does allow for injunctive relief and attorney's fees.[127] In *Cummings*, the court held emotional distress damages are unavailable for plaintiffs seeking to enforce Section 504 and Section 1557 because it looked to common law contract principles, in which emotional distress damages are unavailable as a remedy for breach of contract.[128] The court relied on a prior case, *Barnes v. Gorman*, which held punitive damages are unavailable under common law contract doctrine, and punitive damages are an exception to the general rule which require notice of the potential for these damages.[129] The Court reasoned the statute operates like a contract in which the recipient of federal funds agrees to comply with specific requirements in exchange for the financial assistance.[130] However, the dissent in *Cummings* argued emotional distress damages are available when a breach of contract was likely to result in serious emotional disturbance, and breach of contract due to discrimination is likely to cause emotional suffering.[131] Additionally, other civil rights statutes

[126] Proposed Rule, Nondiscrimination in Health Programs and Activities Subpart D-Procedures, Enforcement Mechanisms § 92.301. HHS-OS-2022–0012.

[127] *Civil Rights Remedies in Cummings and Implications for Title VI and Title IX*, Congressional Research Service, (Jun. 29, 2022), https://crsreports.congress.gov/product/pdf/LSB/LSB10775.

[128] *Id.*

[129] *Id.*

[130] *Id.*

[131] *Id.*

such as Title VII of the Civil Rights Act of 1964 allows for the recovery of emotional distress damages.

Appropriate remedies for disparate impact claims include injunctive relief as well as compensatory and punitive damages. In alignment with the dissent's argument in *Cummings*, breach of contract due to discrimination is an exception to the general rule as the harm is likely to cause emotional distress. Therefore, with discrimination claims, the Court should make punitive damages available. In granting injunctive relief, compensatory damages, and punitive damages, the Court may directly compel the defendant to correct for the harm caused by implicit bias, punish the defendant for noncompliance with the antidiscrimination statute, and compensate the defendants for the harm they suffered. Recognition of harm helps to restore individual dignity and provide financial relief to patients who may have additional medical costs as a result of inadequate care due to bias. Compensatory damages are a way to recognize the harm inflicted by the defendant but also have the effect of deterrence. By recognizing the harm inflicted upon Patient A and Patient B, the court will perform the significant measure of validating their claim and restoring a sense of dignity in addition to providing relief for the harm they suffered. Health care facilities will be concerned about loss of financial resources, not only from damages allocated to patients, but also the costs of litigation. Punitive and compensatory relief will encourage the defendant to monitor and identify bias, and also to enact protocols and guidelines to reduce its consequences. It will deter future discriminatory conduct and promote change. Aside from the Court's analysis, Congress has the ability to amend the language of the statues to explicitly state the availability of equitable relief, injunctive relief, punitive damages, and compensatory damages.[132]

## III. Policy Implications: The Importance and Inadequacy of Litigation

### A. *The Importance of Litigation*

The overall goal of civil rights laws is to promote racial justice. Prohibiting private action in disparate impact claims has reduced litigation and the general advancement of this goal. By relying on the limited resources of government to hold health care institutions accountable for discrimination through enforcement by the US Department of Health and Human Services (HHS) and Office of Civil Rights (OCR) investigations, the opportunity to seek justice has been minimized. Administrative enforcement requires dedication and prioritization

[132] *Id.*

by the administration to remedy the impact of discrimination and a commitment to justice, which can change depending on government leadership. Litigation allows individuals to confront racism and discrimination, but also assists in restoring dignity and self-determination among plaintiffs who have suffered harm. Litigation has historically been a fundamental tool in addressing harms, specifically for marginalized populations. By recognizing harm through a lawsuit and bringing it to the forefront, this assists in galvanizing collective action to correct for these harms outside of the courtroom. Collective action may involve policy change and community efforts. Presenting claims of discrimination against identified victims gives insight into the impacts of subordination and how to challenge it. It also directly calls attention to subordination and its impact on the health and well-being of historically oppressed populations. Critical race rheory scholar, Patricia J. Williams argues that "the Black experience of anonymity, the estrangement of being without a name, has been one of living in the oblivion of society's inverse, beyond the dimension of any consideration at all. Thus, the experience of rights assertion has been one of both solidarity and freedom, of empowerment of an internal and very personal sort; it has been a process of finding the self."[133] The assertion of rights allows for plaintiffs to describe and name the broad occurrence of racism in a claim presented to the court.

B. *Limitations and Critiques*

The new doctrinal framework presented in this paper will expand the ability of litigants to address interpersonal discrimination, however, it will not address structural discrimination that contributes health disparities. This framework may face opposition as one may argue it will limit judicial efficiency and result in a substantial number of claims. However, this may not necessarily result in substantial litigation as the plaintiff still has the burden of presenting a cognizable claim of discrimination and that they experienced a disparate impact caused by the defendant. Additionally, the very purpose of the shift in the doctrinal framework is to allow for more litigation to effectively address the pervasive effects of implicit bias in patient care. Without addressing implicit bias, it will continue to cause harm to patients.

Though litigation is one technique in confronting discrimination as a result of implicit bias, advocacy efforts centered on universal policies, guidelines and protocols in health care facilities, such as those aimed at toxicology screening, is

[133] Patricia J. Williams, *Alchemical Notes: Reconstructing Ideals from Deconstructed Rights*, 22 harv. c.r.-c.l. l. rev. 401 (1987).

another approach. Legislation may produce change by requiring universal policies in health care facilities.

## Conclusion

While private action should be permitted for disparate impact claims, by modifying the current legal framework used to prove a disparate impact claim, advocates can confront implicit bias in the provision of health care, and in turn move toward the elimination of racial health disparities. Traditionally, litigants have been unable so successfully challenge implicit bias because of the need to identify a specific policy or practice as a source of the disparate impact. In eliminating this requirement and assuming the presence of bias, plaintiffs will no longer have the heavy burden of proving a specific policy or practices resulted in the disparate impact. As identified in the civil rights of health framework, population and power are critical pathways that produce health disparities, stemming from oppression and subordination. Litigation is one method to confront the racism that operates through these paths and empower litigants by recognizing their harm and providing relief.