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A THIRTEENTH AMENDMENT CHALLENGE TO BOTH RACIAL DISPARITIES IN MEDICAL TREATMENTS AND IMPROPER PHYSICIANS' INFORMED CONSENT DISCLOSURES

LARRY J. PITTMAN*

I. Introduction

On September 11, 2001, supporters of Osama Bin Laden and his terrorist organization hijacked four domestic airplanes, flying two of them into the World Trade Center Towers in New York City, one of them into the Pentagon, and crashing the last one in rural Pennsylvania while likely en route to the White House, thereby killing approximately three thousand innocent American citizens in what was surely the most heinous act of foreign terrorism ever to occur on American soil.[1] Subsequently, innocent Americans in Washington, D.C., New York, and New Jersey received letters containing anthrax, a poisonous chemical that infected and killed several of the recipients and caused great fear that more Americans would be infected with and die from anthrax, small pox, and whatever other means of mass destruction that terrorists may obtain for the purpose of inflicting great pain and fear upon the American public.[2]

Following these unprecedented evil acts, the President properly instituted a war against Bin Laden, his terrorist network, and the Taliban rulers of Afghanistan.[3] After months of the devastating bombing of Afghanistan, American ground troops entered Afghanistan and defeated some of the terrorist groups.[4] If estimates are correct, African-American soldiers comprised approximately thirty percent of the soldiers who fought in Afghanistan.[5] Probably, the same percentage of African-American soldiers will fight in every other country into which America chases the terrorists who are responsible for

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1. *See* Roger Simon, *Blown Away*, U.S. NEWS & WORLD REP., Sept. 14, 2001, at 16, 18, 23.
2. Scott Shane, *A Year Later*, *Clues on Anthrax Still Few*, BALT. SUN, Oct. 9, 2002, at 1A.
3. Roger Simon, *One Year*, U.S. NEWS & WORLD REP., Sept. 16, 2002, at 16, 20.
4. *See id*.
5. Muhammad Larry, *Love of Freedom*, COURIER-J. (Louisville, Ky.), Feb. 17, 2002, at 1H.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

the heinous attacks, despite the fact that African Americans comprise only approximately twelve percent of the American population.[6]

At some point, the war on terrorism will be over, and white American soldiers will return to America and continue their normal lives. African-American soldiers, however, can only hope that history does not repeat itself regarding their unequal treatment in America. For example, African-American soldiers, after having fought in World War I, World War II, the Korean War, and the Vietnam War to protect and preserve foreign peoples' rights, returned to America where they found few civil rights, little humanity, and not much dignity. African-American soldiers came home to a country where white citizens denied them the right to eat in integrated restaurants, sleep in integrated hotels, live in integrated residential areas, and receive integrated medical treatment in quality medical institutions.[7]

Now, almost sixty years after World War II and approximately thirty years after the Vietnam War, many things have changed as African Americans (of all professions, including soldiers) can live, eat, and sleep in almost any place that they can afford. However, there still is much racial discrimination in America.[8] This statement appears to be especially true concerning access to health care, as shown by the substantial racial disparities that occur across a broad spectrum of medical treatments, even when many African Americans now have access to the financial resources that are necessary to pay for their medical treatments.[9] For example, there are estimates that approximately sixty thousand (60,000) African Americans die annually because of the disparities between the types of medical treatments that physicians and other medical providers make available to African-American patients and to white patients.[10]

6. *Id*.

7. *See, e.g.*, *id*. As a matter of fact, African Americans have fought in every war in which America has been involved since the American Revolution; however, America did not give African-American soldiers the same treatment as white soldiers until President Harry Truman's administration mandated the equal treatment of soldiers by the military while the soldiers were on active duty. Equal treatment while in active service, however, did not prevent the American civilian population in the South and in some Northern states from discriminating against African-American soldiers while they were either on leave or after they left military service. *See id.*

8. *See e.g.*, Ruth Gordon, *Critical Race Theory and International Law: Convergence and Divergence Racing American Foreign Policy*, 94 AM. SOC'Y INT'L L. PROC. 260 (2000). Gordon states:

> Although race continues to pervade all aspects of American life, albeit in constantly evolving, intricate and multidimensional ways, the racialized nature of our culture, our political institutions, our social relationships, indeed the racialized nature of our very being, has become imperceptible to the majority. White supremacy and white privilege are now recognized for the most part only by those who suffer its consequences.

Id. at 264.

9. *See infra* notes 11–81 and accompanying text.

10. Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

Given the substantial disparities in various types of medical treatments, there is presently a debate over whether racism is at least one of the causes of this health care dilemma. This Article adds to that debate.

Part II discusses several studies that show racial disparities in such medical procedures as invasive heart treatments, cancer treatments, kidney transplants, and other medical treatments and procedures, with the outcome that physicians are giving white patients some beneficial treatments that these same physicians are not giving to African Americans and other minorities. There is an indication that these disparities are leading to approximately 60,000 deaths in African-American patients—deaths that could be avoided if the disparities in treatments did not exist. Sadly, the above-referenced studies implicate physicians' racism as being at least one possible cause of the racial disparities. Part III examines the creation and continuation of the black inferiority theory and shows the harmful effects that it has had on many aspects of African Americans' lives, especially its effect on the quality of medical treatments that white physicians provide to African-American patients.

Part IV offers a direct claim under the Thirteenth Amendment as one possible means of alleviating some of the racial disparities in medical treatments. Implicitly, this section argues that slavery and subsequent racism in America have been based upon the alleged black inferiority theory. In the medical profession, physicians, both consciously and unconsciously, used the black inferiority theory to support historical and present racial discrimination against their African-American patients. Therefore, the Thirteenth Amendment should outlaw any racial discrimination by physicians as a "badge and incident" of slavery if such racism is based upon the same black inferiority theory that supported and justified slavery.

This section also outlines the burden of proof for such a direct Thirteenth Amendment claim. Primarily, if African-American or other minority patients can show that they were denied medical treatment that their treating physician disproportionately provided to white patients, the burdens of production and persuasion would shift to the physician to show: (1) that the giving of the different or lesser treatment to minority patients served a compelling state or legitimate private interest; (2) that the practice was narrowly tailored to the achievement of the asserted interest, and (3) that there were no less restrictive alternatives to achieve the asserted interest. Pure racism for its own sake, no

191, 206 (1996). Given the devastating effects of racial discrimination in the health care industry, this Article proposes that the Supreme Court of the United States establish a direct claim under the Thirteenth Amendment for physicians' and other medical providers' racial discrimination against African Americans and other minority patients. *See infra* notes 205–211 and accompanying text (analyzing the legislative history of the Thirteenth Amendment and the type of "dynamic interpretation" of the Amendment that the Court can use to create a direct claim under the Amendment).

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

matter how it is spun or packaged, should never be allowed to satisfy the above-referenced test.

Part V argues that the informed consent doctrine should be altered to mandate that physicians, as a part of their informed consent disclosures, tell African Americans and other minorities that there is a disparity between the types of treatments that physicians have historically recommended for them and the treatments that physicians have recommended for white patients. Physicians should also explain in sufficient detail the reasons for the disparities in recommendations and treatments, thus allowing minority patients an opportunity to take actions to avoid any harm that might flow to them from the disparities, including seeking treatment from another physician. This section also concludes that the failure to give the proposed informed consent disclosure would violate the Thirteenth Amendment.

II. ANALYSIS OF VARIOUS TYPES OF RACIAL DISPARITIES IN MEDICAL TREATMENTS

Of all of the body's organs, the heart is one of the most important. This assertion is especially true given that heart disease is the leading cause of death in American women.[11] Therefore, the medical profession and society in general should have a considerable interest in providing heart disease treatments on a nondiscriminatory basis. A substantial body of medical studies show, however, that physicians do not give African-American heart patients the same types of treatments that they give to their white patients.

For example, a study reported in 1993 examined the medical records of approximately 800,000 veterans[12] to determine the frequency of invasive surgical procedures such as "cardiac catheterization, percutaneous transluminal coronary angioplasty, or coronary artery bypass grafting" and concluded that "[e]ven when financial incentives are absent, whites are more likely than blacks to undergo invasive cardiac procedures."[13] These researchers concluded, "We believe that inadequate health education, differences in patients' preferences for invasive management, delivery systems that are unfriendly to members of certain cultures, and overt racism may all play a

11. Dyann Matson Koffman et al., *An Evaluation of Choose to Move 1999: An American Heart Association Physical Activity Program for Women*, 161 ARCHIVES OF INTERNAL MED. 2193, 2193 (2001).

12. Jeff Whittle et al., *Racial Differences in the Use of Invasive Cardiovascular Procedures in the Department of Veterans Affairs Medical System*, 329 NEW ENG. J. MED. 621, 622 (1993). The study considered white and African-American male patients who sought treatment at Veterans Affairs (VA) hospitals throughout America from 1987 through 1991. *Id.* at 621.

13. *Id*. The differences were statistically significant. The article noted that white veterans were 1.38 times more likely than African-American veterans to undergo cardiac catheterization, one and a half times more likely to undergo angioplasty, and more than two times more likely to undergo coronary artery bypass surgery. *Id*.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

part."[14] Consistently, other studies have shown racial disparities in various types of heart treatments that are probably caused, in part, by physicians' racism.[15] Also, in a recent report by the Institute of Medicine ("IOM"), entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*,[16] a committee reviewed more than one hundred studies and gave its opinions, stating:

> The preponderance of studies, however, find that even after adjustment for many potentially confounding factors—including racial differences in access to care, disease severity, site of care (e.g., geographic variation or type of hospital or clinic), disease prevalence, comorbidities or clinical characteristics, refusal rates, and overuse of services by whites—racial and ethnic disparities in cardiovascular care remain.[17]

14. *Id*. at 626. More importantly, this study shows that patients' incomes were not a controlling factor in causing the disparity in medical treatments because the patients received free treatments at VA hospitals. *See id*. at 621.

15. *See generally* Joseph Conigliaro et al., *Understanding Racial Variation in the Use of Coronary Revascularization Procedures: The Role of Clinical Factors*, 160 ARCHIVES OF INTERNAL MED. 1329 (2000); Edward L. Hannan et al., *Access to Coronary Artery Bypass Surgery by Race/Ethnicity and Gender Among Patients Who Are Appropriate for Surgery*, 37 MED. CARE 68 (1999); Eric D. Peterson et al., *Racial Variation in Cardiac Procedure Use and Survival Following Acute Myocardial Infraction in the Department of Veterans Affairs*, 271 JAMA 1175 (1994).

A 1999 study concluded that "the race and sex of the patient affected the physicians' decisions about whether to refer patients with chest pain for cardiac catheterization, even after . . . adjust[ment] for symptoms, the physicians' estimates of the probability of coronary disease, and clinical characteristics." Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618, 623 (1999). These researchers asserted that some of the disparity in treatment might be caused either by a physician's overt or subconscious biased attitudes. *Id*. at 624-25. The researchers further stated:

> However, our study could not assess the form of bias. Bias may represent overt prejudice on the part of physicians or, more likely, could be the result of subconscious perceptions rather than deliberate actions or thoughts. Subconscious bias occurs when a patient's membership in a target group automatically activates a cultural stereotype in the physician's memory regardless of the level of prejudice the physician has.

Id. (endnotes omitted). The researchers concluded that the racial disparities in the physicians' referrals for cardiac catheterization "suggest that decision making by physicians may be an important factor in explaining differences in the treatment of cardiovascular disease with respect to race and sex." *Id*. at 625.

16. COMMITTEE ON UNDERSTANDING AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley et al., eds., 2003) [hereinafter UNEQUAL TREATMENT].

17. *Id*. at 42. For a list of the medical studies concerning cardiovascular disease that the committee reviewed, *see id.* app. B–1 at 306-25 (Literature Review).

This committee found that "research suggests that healthcare providers' diagnostic and treatment decisions, as well as their feelings about patients, are influenced by patients' race or ethnicity."[18]

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18. *Id.* at 11. In light of the above-discussed studies, including the Institute of Medicine report, at least one question arises. If racism is a cause of the racial disparity in medical treatments, one might expect that the race of the treating physicians would have a bearing on the types of procedures that African Americans undergo. But a May 2001 study made an interesting observation: "Black patients had lower rates of cardiac catheterization than white patients, regardless of whether their attending physician was white (rate of catheterization, 38.4 percent vs. 45.7 percent . . .) or black (38.2 percent vs. 49.6 percent . . .)." Jersey Chen et al., *Racial Differences in the Use of Cardiac Catheterization After Acute Myocardial Infarction*, 344 NEW ENG. J. MED. 1443, 1443 (2001).

Though Chen's conclusion may be more indicative of the absence of overt racism, it does not foreclose the possibility that some white physicians and some African-American physicians might be motivated by unconscious racism when they treat African-American patients, as some commentators have recognized:

> [B]oth white and black physicians may have subtle biases that are based on other social factors and that influence their judgments about patients' suitability for procedures. For example, previous research has documented difficulties in communication about cardiac testing between physicians and patients of lower socioeconomic status, and physicians report personal perceptions of less affluent or less well educated patients that are more negative than their perceptions of other patients. Black patients are disproportionately represented in these socioeconomic groups.

Arnold M. Epstein & John Z. Ayanian, *Racial Disparities in Medical Care*, 344 NEW ENG. J. MED. 1471, 1472 (2001) (endnotes omitted).

This observation is consistent with my beliefs that the black inferiority theory has infected both white people and African Americans such that both races, and all other races and ethnic groups, have a tendency to treat African Americans differently, frequently to African Americans' detriment. Therefore, before one uses the Chen study to exclude racism as one of the causes of the racial disparity in medical treatments, he or she should consider the insidious nature of racism and the effects that it has had, and is having, on the psyche of Americans of all colors and races. *See* Frank M. McClellan, *Is Managed Care Good For What Ails You? Ruminations on Race, Age and Class*, 44 VILL. L. REV. 227, 246 (1999). The author noted that "[b]lack professionals did not see the Tuskegee Study as a threat to their families or friends. Somehow, despite the commonality of race, the physicians were able to separate themselves from the victims and see them as the 'the other.'". *Id.*

Additionally, because of the existence of racial disparities in medical treatments, one can reasonably expect that African Americans and other minorities have suffered injuries from the different treatments that they have received. One study asserted that African Americans' mortality rates and rates of future recurrent ischemic events were similar to the rates of white patients who received more angiography, intensive anti-ischemic medication, and revascularization procedures. Peter H. Stone et al., *Influence of Race, Sex, and Age on Management of Unstable Angina and Non-Q-Wave Myocardial Infarction: The TIMI III Registry*, 275 JAMA 1104, 1108 (1996). This conclusion tends to show that the racial disparity in treatments did not worsen African Americans' mortality rates. *See id.*

However, even if the Stone study showing no effect on African Americans' mortality rates is accurate, such a conclusion would not alleviate the possibility that African-American patients might have received other health benefits (such as an improved quality of life) had they

As with heart treatments, racial disparities exist for cancer treatments. For example, physicians do not offer their African-American patients surgeries for early-stage resectable non-small-cell lung cancer (stage I or II) as frequently as they offer such treatments to their white patients, even though that surgery is very effective in curing such cancer.[19] Additionally, the above-referenced IOM report made several observations about racial disparities in cancer treatments. First, African-American women with breast cancer received fewer

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received the same rate of heart treatments as white patients. For example, the IOM committee stated:

> In addition, a finding of no racial or ethnic differences in patient outcomes (e.g., survival) despite disparate rates of treatment should not be interpreted as demonstrating that disparities in the use of medical intervention are inconsequential. In such instances, researchers should ask whether equivalent rates of intervention might be associated with *better* patient outcomes among minorities.

UNEQUAL TREATMENT, *supra* note 16, at 52-53.

And, in contrast to Stone's study, a Duke University Medical Center study of 12,402 patients found that because African-American patients received fewer bypass surgeries and angioplasties than whites, they experienced "lower rates of survival for five years" given that African Americans were "18 percent more likely to die than whites during the five years of follow-up." Eric D. Peterson et al., *Racial Variation in the Use of Coronary-Revascularization Procedures—Are the Differences Real? Do They Matter?*, 336 NEW ENG. J. MED 480, 484 (1997). The disparity in treatment was not caused by the medical or other clinical conditions of the patients. *Id*. This study indicates that the longer African Americans live after heart treatments, the more likely the racial disparity will have a negative impact on their mortality rates. *Id*. at 484.

19. *See* Peter B. Bach et al., *Racial Differences in the Treatment of Early-Stage Lung Cancer*, 341 NEW ENG. J. MED. 1198, 1198 (1999). The study consisted of 860 African Americans and 10,124 white Americans 65 and older with Medicare payments for their medical treatments. *Id.* at 1200. The researchers found that "[t]he rate of surgery was 12.7 percentage points lower for black patients than for white patients (64.0 percent vs. 76.7 percent . . .), and the five-year survival rate was also lower for blacks (26.4 percent vs. 34.1 percent . . .)." *Id*. at 1198. The survival rate was similar for African Americans and white Americans who underwent surgery and for members of both groups who did not undergo surgery. *Id*. The researchers concluded that the lower rate of surgery for African-American patients explains the lower survival rates for African Americans who had "early-stage, non-small-cell lung cancer." *Id*. Instead of focusing on African-American patients' preferences, the Bach study concluded that "[a]n alternative explanation is that black patients are offered optimal treatment less frequently than their white counterparts." *Id*. at 1204. This study at least suggests that the race of the African-American patients had something to do with physicians' not recommending surgery to them, given that the researchers controlled the study for socioeconomic conditions and other illnesses. *See id.* at 1201-02.

The Bach study is very disturbing given that surgery is very effective in curing and in increasing the survival rates of patients with "early-stage, non-small-cell lung cancer." *See id*. at 1204. The fact that African Americans underwent surgery less frequently than white Americans (and suffered an increase in mortality rates because of the failure to have the surgery) is especially troubling. This disparity becomes even more problematic if physicians' failure to recommend surgical intervention is both a substantial factor in African Americans' failure to undergo surgery and is because of physicians' racially biased attitudes. *See id*. at 1204.

"progesterone receptor assays . . . , were less likely to receive radiation therapy in combination with radical/modified mastectomy, and were less likely to receive rehabilitation support services following mastectomy."[20] Second, African-American men, at all ages studied, received fewer "radical prostatectomy and radiation to treat prostate cancer."[21] Third, African Americans "received less effective diagnostic evaluations" for colon cancer.[22] Fourth, African-American cancer patients received less "post-treatment surveillance care."[23] Fifth, "African-American women with invasive cervical cancer" were more likely than white women to have their physician not recommend treatment of the disease.[24] Sixth, African-American men with colorectal non metastasis cancer were "41% less likely than whites to receive a major procedure for treatment" of their cancer, while those with metastasis cancer were "27% less likely to receive a major treatment."[25]

The IOM report made observations about disparities in other treatments as well. For instance, African-American patients received less pain medication to treat their medical condition in nursing homes, and they had "a 63% greater probability of being untreated for pain relative to whites."[26] Also, African Americans who received their medical treatments in medical facilities that primarily treat minority patients received less pain medication than white patients who received their treatments in facilities that primarily treat white patients.[27] Finally, in certain veteran administration hospitals, African-American patients were less likely to have surgery than white patients who had "esophageal adenocarcinoma."[28]

Consistent with the above-referenced types of cancer treatments, there is a racial disparity regarding African-American breast cancer patients, as the mortality rates for African-American females is higher than the rates for white females.[29] Some researchers blame physicians for that disparity because a

20. UNEQUAL TREATMENT, *supra* note 16, at 53.
21. *Id*.
22. *Id*. at 54.
23. *Id*.
24. *Id*.
25. UNEQUAL TREATMENT, *supra* note 16, at 55.
26. *Id*. at 55-56.
27. *See id*.
28. *Id*. at 57.
29. Donald R. Lannin et al., *Influence of Socioeconomic and Cultural Factors on Racial Differences in Late-Stage Presentation of Breast Cancer*, 279 JAMA 1801, 1801 (1998). Some researchers believe that, as an effort to promote earlier diagnosis of breast cancer in African-American women, physicians should become better informed of the cultural and religious beliefs of such patients and use that information to better inform African-American breast cancer patients of the risks and benefits of various medical treatments. *See id*. at 1807.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

physician's recommendation of a screening mammography is the major factor that influences a woman's decision to undergo the procedure.[30]

There is also a racial disparity in kidney transplants. A study published in 1999 arranged for the interviews of 1,392 patients (384 African-American women, 354 white women, 337 African-American men, and 317 white men) who had a diagnosis of "end-stage renal disease," with the study being controlled to alleviate effects from differences in socioeconomic and demographic backgrounds, other illnesses, patients' preferences, "expectations about transplantation," "perceptions of care," and "type of dialysis facility."[31] The researchers concluded:

> Among patients who wanted a transplant, blacks remained significantly less likely than whites to have been referred for evaluation and significantly less likely to have been placed on a waiting list or to have received a transplant within 18 months after the start of dialysis therapy . . . . Even among the patients who said they were very certain that they wanted a transplant, blacks were substantially less likely than whites to have been referred for evaluation (62.8 percent of black women vs. 83.6 percent of white women, and 62.0 percent of black men vs. 83.2 percent of white men . . .) and were substantially less likely to have been placed on a waiting list or to have received a transplant within 18 months after the start of dialysis therapy (44.2 percent vs. 71.4 percent and 45.4 percent vs. 70.8 percent, respectively . . .).[32]

These researchers found that patients' preferences "explained only a small part of the racial differences in rates of referral and of placement on a waiting list for transplantation" and that "[r]acial differences in access to transplantation remained significant after adjustment for sociodemographic factors, health status, perceptions of care, and coexisting illnesses."[33]

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30. Michael S. O'Malley et al., *Race and Mammography Use in Two North Carolina Counties*, 87 AM. J. PUB. HEALTH 782, 785 (1997).

31. John Z. Ayanian et al., *The Effect of Patients' Preferences on Racial Differences in Access to Renal Transplantation*, 341 NEW ENG. J. MED. 1661, 1661 (1999).

32. *Id*. at 1663-64.

33. *Id*. at 1667. These researchers cautiously stopped short of stating that racial discrimination was the cause of the disparity of treatment:

> Although few patients reported recent discrimination on the basis of their race, income, or sex, we believe blacks may be more likely than whites to encounter problems in communicating with their physicians and may have less trust in the health care system, as suggested by our data and the preliminary results of one qualitative study.

Id. (endnotes omitted).

However, it is not surprising that the African-American patients did not complain about physicians' racial discrimination, given that a substantial amount of discrimination is covert and therefore difficult to discover. *See generally* Barbara A. Noah, *The Invisible Patient*, 2002 U. ILL. L. REV. 121 (2002) (book review). Even if there were a communication problem between white physicians and their African-American patients (to a greater degree than with their white patients), the existence of such a difference in patients' communications with their white physicians would be some indication of racism, for it is not reasonable to believe that African

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

A subsequent study based upon the same data as the above-discussed kidney transplant research concluded:

> Black patients were less likely than white patients to be rated as appropriate candidates for transplantation according to appropriateness criteria based on expert opinion (71 blacks [9.0 percent] vs. 152 whites [20.9 percent]) and were more likely to have had incomplete evaluations (368 [46.5 percent] vs. 282 [38.8 percent] . . .). Among patients considered to be appropriate candidates for transplantation, blacks were less likely than whites to be referred for evaluation, according to the chart review (90.1 percent vs. 98.0 percent . . .), to be placed on a waiting list (71.0 percent vs. 86.7 percent . . .), or to undergo transplantation (16.9 percent vs. 52.0 percent . . .). Among patients classified as inappropriate candidates, whites were more likely than blacks to be referred for evaluation (57.8 percent vs. 38.4 percent), to be placed on a waiting list (30.9 percent vs. 17.4 percent), and to undergo transplantation (10.3 percent vs. 2.2 percent . . .).[34]

These researchers concluded that such factors as the differences in clinical characteristics, the underuse of transplantation among blacks, and the overuse among whites caused the racial differences in the rates of kidney transplants.[35] Interestingly, the researchers found that there was an underuse of kidney transplants by African Americans and an over-use by white Americans even when a transplant was deemed inappropriate.[36] This pattern of underuse of transplants by African Americans, regardless of their medical suitability, is suggestive of racial discrimination against African Americans.[37] This conclusion is especially warranted because the racial disparity in kidney

Americans have a more difficult time in understanding their physicians' discussions on the advantages and disadvantages of a treatment like a kidney transplant, regardless of their educational levels, if physicians really make a genuine effort to communicate the benefits and risks of the various types of kidney treatments.

It is only reasonable to believe that any difficulty that some African Americans have, in their communication abilities or in their abilities to understand physicians' statements, can be alleviated if physicians better inform themselves about the limitations of their patients' communication abilities and if they assert a little more effort in making certain that their patients understand information about the benefits and risks of recommended treatments. *See* O'Malley, *supra* note 30, at 785. In any event, no one should use some African Americans' alleged communication problems as an excuse for the racial disparities in various medical treatments.

34. Arnold M. Epstein et al., *Racial Disparities in Access to Renal Transplantation: Clinically Appropriate or Due to Underuse or Overuse*?, 343 NEW ENG. J. MED. 1537, 1537 (2000).

35. *Id*.

36. *Id*. at 1540-42.

37. African-American patients' preferences do not explain all of the disparities in medical treatments. *See* UNEQUAL TREATMENT, *supra* note 16, at 7. This statement is especially true given that African Americans' preferences for or against kidney transplants do not cause much of the disparity in kidney transplants. *See* Ayanian et al., *supra* note 31, at 1663-64.

transplants exists even when adjustments are made for "sociodemographic characteristics and health status."[38]

Some researchers have concluded that an analysis should be made into each of the four steps of the kidney transplant process to determine whether there are barriers at each step that contribute to the racial disparity in kidney transplants.[39] Because African Americans encounter difficulties and barriers at each step, researchers should study African Americans' interaction and communication with their white treating physicians.[40] In other words, white physicians' conscious or unconscious racial prejudices might be influencing their evaluation of African-American patients and their recommendations of kidney transplants for such patients.

In addition to physicians' probable racial bias against African Americans, the federal government's insensitivity to the disproportionate impact that its kidney transplant criteria have on African Americans might also be one of the

38. UNEQUAL TREATMENT, *supra* note 16, at 59. Other studies, as reviewed by the above-referenced Institute of Medicine review committee, show the racial disparities in kidney transplants. For example, studies show that African Americans "are less likely than similar white patients to receive a kidney transplant," and are "less likely than white patients to be referred for transplantation and to appear on waiting lists within the first year of Medicare eligibility." *Id.* at 58 (citations omitted). African Americans are also "less likely to be judged as appropriate for transplantation, are less likely to appear on transplantation waiting lists, and are less likely to undergo transplantation procedures, even after patients' insurance status and other factors are considered." *Id.* at 58-59.

It is not reasonable to believe that African Americans, if given appropriate informed consent, would disproportionately forgo kidney transplants, especially because studies have shown that, even when African Americans want transplants, there is a racial disparity between them and white patients. *See* Ayanian et al., *supra* note 31, at 1663-64.

39. *See generally* G. Caleb Alexander, *Barriers to Cadaveric Renal Transplantation Among Blacks, Women, and the Poor*, 280 JAMA 1148 (1998). These steps are: "(A) being medically suitable and possibly interested in transplantation, (B) being definitely interested in transplantation, (C) completing the pretransplant workup, and (D) moving up a waiting list and receiving a transplant." *Id.* at 1151. These researchers found that for African Americans, "[s]teps B through D are the most important impediments." *Id.*

40. *See id.* For example, at step C, the pretransplant workup, the researchers noted that tasks performed at that step "may include referral to transplant surgeons, evaluation and treatment of medical conditions, and laboratory studies such as tissue typing." *Id.* at 1151. These are tasks that treating physicians can influence. *See id.* For the most part, African-American patients' medical conditions did not warrant that they stay in step C. *See id.* The research noted that only three percent of the patients who did not complete step C were deemed "'not a transplant candidate' or 'undecided.'" *Id.* The researchers theorized and speculated that the following might be reasons why African Americans do not make it out of step C: "biological and medical variables, lack of knowledge about transplantation, and concerns about surgery, adverse effects of medication, and health care costs. Possible provider factors include subconscious bias and financial disincentives. Transplant center size and proximity, as well as regional variations in matching algorithms, may also play a role." *Id.* (endnotes omitted). An understanding of how the above possible factors affect African Americans and others at each step of the kidney transplant process may help reduce the racial disparities in kidney transplants. *Id.*

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

causes of the racial disparity. For example, the National Organ Transplant Act[41] and the federal regulations thereunder give organ transplant priority to those patients who have either a zero mismatch (of six antigens) with the kidney donor or who have the fewest mismatches.[42] Because antigens appear differently in African Americans than in white people, white people are more likely to have a zero mismatch for an available kidney because more white people donate kidneys than African Americans, a result that is mostly because of the make-up of the American population.[43] Therefore, because of the federal government's antigen match allocation system, white people will disproportionately receive more kidney transplants than African Americans.[44]

This conclusion is unsettling given that there may be other criteria that could be used to allocate kidneys.[45] There is some evidence that a program for kidney transplants that is not primarily based upon the matching of antigens can be established through the use of drugs that minimize the risk of a transplant rejection.[46] In other words, there is evidence that a patient who has some antigen mismatch, but who is neither a zero mismatch nor a six mismatch, has only a small percentage increase in the risk of rejection compared to others who have less than a zero mismatch.[47] If this evidence is accurate, the federal government's present use of the antigen-match system is

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41. National Organ Transplant Act, Pub. L. No. 98-507, 98 Stat. 2339 (1984) (codified as amended at 42 U.S.C. §§ 273-274 (2000)).

42. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 76 (4th ed. 2001).

43. *See id*. Presently, African Americans, who comprise approximate twelve percent of the population, donate approximately thirteen percent of the kidneys. However, because more African Americans suffer from end stage renal disease, they need more kidneys than they donate. *See id.* One commentator has stated that "to level off the zero antigen mismatch standard the donation rate for African-Americans would have to increase five times over the current rate for African-Americans and four times over the current rate for white donors." *Id*. at 77.

44. *See generally* Robert S. Gaston et al., *Racial Equity in Renal Transplantation: The Disparate Impact of HLA-Based Allocation*, 270 JAMA 1352 (1993) (discussing the racial disparity in kidney transplants that the federal antigen-matching allocation criterion causes). This advantage for white Americans exists despite the fact that African Americans disproportionately have had more end-stage renal disease than white Americans and despite their frequently comprising a majority of the patients who are on the waiting list for kidney transplants. FURROW ET AL., *supra* note 42, at 76 (asserting that white people "received 63% of donated kidneys between 1994 and 1998").

45. *See* Gaston et al., *supra* note 44, at 1355.

46. *See id*.

47. *See id.* at 1354 (arguing for a change in the federal program such that kidneys will be allocated through a program that relies less on antigen matching). *See also* FURROW ET AL., *supra* note 42, at 77 (asserting that "[d]ata from 1999 indicate graft one-year survival rates for cadaveric kidney transplants of 86.7% for mismatch of five antigens; 87.5% for four; 88.6% for three; 88.3% for two; and 90.1 when there is only one mismatch," and asking the question: "Are these differences significant?").

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

not justified given the disproportionate impact that it has on African Americans' access to kidney transplants.[48]

A reasonable conclusion from the above discussion is that white physicians' racial prejudices and the federal government's antigen matching system are the causes of that portion of the racial disparity in kidney transplants for African Americans that is not because of their preferences, health status, and socioeconomic status.[49] Presently, African Americans encounter a racial disparity in kidney treatments from the beginning phases of end-stage renal disease until the conclusion of their treatments, including physicians' referral for kidney transplant evaluations, patients' placement on transplant waiting lists, and patients' actual receipt of kidney transplants.[50] Clearly, some efforts should be taken to bring equity to the allocation of kidneys.[51]

Not only are African Americans at a racial disadvantage when it comes to the above-described medical treatments, they also disproportionately receive less adequate treatment for pain.[52] For example, African Americans receive inadequate doses of pain medication during emergency room treatments,

48. *See infra* notes 225–33 and accompanying text.

49. The racial disparity in kidney transplants is problematic because, although African Americans comprise approximately twelve percent of the United States population, they are approximately thirty-one percent of the patients with end-stage renal disease. Gaston et al., *supra* note 44, at 1352; *see also* FURROW ET AL., *supra* note 42, at 76 (asserting that "end stage renal disease is much more prevalent among African-Americans, at nearly four times the rate of the white population"). In 1997, the rate of kidney disease in African Americans was approximately four times the rate in white Americans. Carlton J. Young et al., *Renal Transplantation in Black Americans*, 343 NEW ENG. J. MED. 1545, 1545 (2000); *see also* FURROW ET AL., *supra* note 42, at 76 (asserting that "African-Americans [have end stage renal disease at] nearly four times the rate of the white population"). High blood pressure may be one of the causes of the disease in African Americans. *See* Young, *supra* (noting that "hypertension among blacks in America remains the highest of any subpopulation in the world"). Apparently, some African Americans' kidneys have a genetic disposition to retain salt, which along with their excessive consumption of salt, contributes to the cause of high blood pressure and "end-stage renal disease." *See id*. Some researchers have linked this genetic disposition to the slave trade when African Americans were transported as slaves for long periods of time on ships without much water or salt. As a result, more genetic pressure was exerted favoring survival of those equipped for the retention of salt. *See* Cara A. Fauci, Note, *Racism and Health Care in America: Legal Responses to Racial Disparities in the Allocation of Kidneys*, 21 B.C. THIRD WORLD L.J. 35, 54 & n.183 (2001). When combined with a high consumption of salt, excessive retention of salt in the system causes high blood pressure and resulting kidney disease. *See id.* at 54.

50. *See id*. at 54-56.

51. See *infra* text accompanying notes 225–33.

52. *See generally* Vence L. Bonham, *Race, Ethnicity, and Pain Treatment: Striving to Understand the Causes and Solutions to the Disparities in Pain Treatment*, 29 J.L. MED. & ETHICS 52 (2001) (discussing the possible reasons why minorities receive less treatment for pain, including race, ethnicity, language barriers, inadequate physician-patient communication, and socioeconomic position).

inadequate pain medication for long bone fractures,[53] and inadequate treatment of pain after surgery.[54] They also receive less "intensive care for pneumonia" and more C-sections to deliver their babies.[55] Similarly, a racial disparity exists even in treatments like influenza vaccinations where there does not appear to be a substantial risk from the treatment.[56] For African-American patients, physicians may not recommend or discuss the benefits and risks of influenza vaccinations to the same degree that they discuss such treatments with their white patients.[57]

In addition, African-American patients, even when they are similarly situated as white patients (same preferences, insurance status, and health conditions), receive less medical treatments for HIV/AIDS infection.[58] Also, at least one study shows that African Americans are less likely than white Americans to receive certain medications for the management of chronic asthma and have fewer referrals to specialists for asthmatic treatments.[59] Other studies show that African-American patients receive different treatments for diabetes than white patients.[60] One study shows that African-American elderly patients with hip fractures receive less physical and occupational therapy than similarly-situated white patients.[61]

Consistent with the above discussion, African-American females receive fewer amniocentesis, fewer ultrasonography, and less tocolysis for treatment of plural births than white women.[62] Similarly, physicians give less advice to single African-American female patients than to single white patients regarding the risks of taking drugs,[63] smoking and drinking alcohol.[64] African-

53. *See id.* at 54 (citing Knox H. Todd et al., *Ethnicity and Analgesic Practice*, 35 ANNALS EMERG. MED. 11 (2000)).

54. *See id.* at 59 (citing Bernardo Ng et al., *The Effect of Ethnicity on Prescriptions for Patient-Controlled Analgesia for Post-Operative Pain*, PAIN, July 1996, at 9).

55. *See generally* Vernellia R. Randall, *Racist Health Care: Reforming An Unjust Health Care System to Meet the Needs of African-Americans*, 3 HEALTH MATRIX 127 (1993) (concluding that physicians' racial discrimination is a primary cause of the racial disparity in such treatments).

56. Eric C. Schneider et al., *Racial Disparity in Influenza Vaccination*: *Does Managed Care Narrow the Gap Between African Americans and Whites*?, 286 JAMA 1455 (2001). Importantly, patients' preferences were not the "sole predictors of whether beneficiaries receive[d] vaccination." *Id*. at 1459.

57. *See id*. (asserting that one possible cause may be the "failure of clinicians to vaccinate minority patients during health care visits"). Other than such apparent racism, there does not appear to be a real explanation for such a disparity in physicians' informed consent disclosure regarding influenza vaccinations.

58. UNEQUAL TREATMENT, *supra* note 16, at 61-62.

59. *See id*. at 62-63.

60. *See id*. at 64.

61. *See id*. at 66.

62. *See id*. at 67. African-American women receive less tocolysis care despite having plural births more frequently than white women. *See id.*

63. UNEQUAL TREATMENT, *supra* note 16, at 67-68.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

American children and Hispanic children receive less pain medication than white children.[65] African-American mental health patients experience "striking disparities" in the provision of mental health services and therefore have less trust in and more fear of the mental health care profession.[66]

As further evidence of racism, African Americans with glaucoma received approximately half of the expected "argon laser trabeculoplasty or trabeculectomy surgery,"[67] and African Americans "who underwent cholecystectomy were less likely than white patients to undergo the laparoscopic procedure."[68] These racial disparities are consistent with other studies of the lengths of hospitalization that have shown that "African-American patients had a shorter length of stay and lower resource use in the first seven days compared with white patients."[69] In fact, the only major treatments that African-American patients receive more of are the treatments that no one really wants, limb amputations for diabetes and bilateral orchiectomy—the surgical removal of a male's testicles.[70]

If the above discussion is not enough to show the substantial racial disparities in medical treatment, other examples can be found by reviewing the IOM report.[71] Interestingly, despite the above-referenced studies (that are controlled for income, patients' preferences, degree of illnesses, and for many other factors), some researchers and commentators are still hesitant to conclude that physicians' racial discrimination is a cause of some of the racial disparities in medical treatments.[72] However, given the complexity of medical treatments and the many factors—some of which are outside the patient's expertise and knowledge—that influence the interaction between African-American patients and their white physicians, it seems only reasonable that legal scholars, attorneys, and courts should recognize a presumption of physicians' racial discrimination.

Even if one is hesitant about asserting physicians' racism as a cause of the racial disparities, he or she should not have too much difficulty with a court's recognition of a rebuttable presumption of physicians' racial discrimination

64. *See id*.

65. *See id*. at 68.

66. *Id*. at 69.

67. *Id*. at 71.

68. UNEQUAL TREATMENT, *supra* note16, at 71.

69. *Id*. at 72.

70. *See id.* at 74 (citing various studies). It appears that African Americans will receive more of a type of treatment than white patients only when the treatment is potentially harmful; for example, physicians give African Americans more antipsychotic medication than they give to white Americans. But for anti-depression drugs, physicians give white Americans more of such drugs. *Id*. at 70.

71. For discussion of other treatments, *see id*. at 71-74.

72. *See generally* Chen et al., *supra* note 18 (implying that the race of the treating physicians has no impact on the racial disparity between white and African-American patients).

when African-American and other minority patients receive less beneficial medical treatments than white patients.[73] A presumption is especially necessary because without it, in most cases, it will be almost impossible to discover covert acts of racial discrimination.[74] This conclusion is proper given the covert nature of present day discrimination and the vast opportunities, enhanced by the complexities of medical practice, that physicians have to hide their discrimination.[75]

The above discussion, including its analysis of various studies, clearly shows that there is a substantial amount of racial disparity in medical treatments.[76] There is uncertainty, however, regarding the causes of the disparity.[77] Some commentators have noted that different patients have different preferences for certain types of treatments.[78] It is doubtful that such differences in preferences are either the sole cause, or even a substantial cause, of the racial disparities in various types of medical treatments.[79] For example, studies have shown that African Americans' preferences against certain

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73. Such a presumption, after an affected minority patient shows a prima facie case, would place the burden on physicians to explain why there is a disparity in the different types of treatments that the physicians give to their patients. *See also infra* text accompanying notes 223–33.

74. *See* Int'l Bhd. of Teamsters v. United States, 431 U.S. 324, 340 n.20 (1977). "In many cases the only available avenue of proof is the use of racial statistics to uncover clandestine and covert discrimination by the employer or union involved." *Id.* (quoting United States v. Ironworkers Local 86, 443 F.2d 544, 551 (9th Cir. 1971)).

75. *See generally* Patricia A. King & Leslie E. Wolf, *Empowering and Protecting Patients: Lessons for Physician-Assisted Suicide From the African-American Experience*, 82 MINN. L. REV. 1015 (1998) (asserting that disparity in treatment exists even when adjustments are made such that African Americans and whites have equal access to treatments; that all of the disparity cannot be attributed to African Americans' preferences against certain medical treatments; and that physicians' unconscious bias may be among the causes of some of the racial disparities in medical treatments); *see also* H. Jack Geiger, *Race and Health Care—An American Dilemma*?, 335 NEW ENG. J. MED. 815, 816 (1996) (noting that "if racism is involved it is unlikely to be overt or even conscious").

76. Given the historical racism in the health care industry, it is also reasonable to believe that physicians' racism is a contributing cause of some of the racial disparities in the health care industry.

77. *See* Bonham, *supra* note 52.

78. For example, African Americans in general may have less of a preference for coronary bypass surgery. *See* Peterson et al., *supra* note 18, at 485 (asserting that African Americans are more likely to disagree with physicians' opinion that bypass surgery is indicated); King & Wolf, *supra* note 75, at 1036 (stating that "the Coronary Artery Surgery Study found that whites were more likely than blacks to elect to have bypass surgery"). African Americans with kidney disease also have less of a preference for kidney transplantation. Ayanian et al., *supra* note 31, at 1661. However, these preferences "explain only a small fraction of the substantial racial differences in access to transplantation." *Id.*

79. UNEQUAL TREATMENT, *supra* note 16, at 7 (asserting that African-American patients' preferences do not explain all of the disparity in medical treatments).

treatments are not the cause of much of the racial disparities in medical treatments.[80] Also, to the extent that African Americans and other minorities have preferences against certain medical treatments, some of their choices against treatment might stem from fear of present racism (which might be based upon their knowledge of historical racial discrimination in the health care industry) and from physicians' failure to inform such patients of the full range of their treatment options.[81]

III. PHYSICIANS' AND OTHER MEDICAL PROVIDERS' RACISM AS A POSSIBLE CAUSE OF THE RACIAL DISPARITIES IN MEDICAL TREATMENTS

To the extent that physicians' racism is a contributing cause of some of the racial disparities in medical treatments, the remaining portions of this Article offer a means of combating such discrimination. To fully consider physicians' and other providers' present racial attitudes about their African-American patients, one should start with an analysis of the historical racism against African Americans. The central theme is that racism, through the institutionalization of the black inferiority theory, has been passed down from one generation of white people to another and that the theory presently infects physicians' and other medical providers' judgment about the type of medical treatments that they should give to African Americans and other minorities.

A. African Americans' Status as an Alleged Racially Inferior Group

Initially, some might be hesitant to presume that racism is at least one cause of the present racial disparities in medical treatment, but a brief review of the persistent existence and effects of racism in this country will show that such a presumption is within the bounds of reason. No knowledgeable person can seriously doubt that for more than four centuries, many white Americans have considered African Americans to be of an inferior race—one suited for working jobs inferior to those held by whites, for living in places inferior to places where whites live, and for enjoying freedoms inferior to those that white Americans enjoy.[82] This black inferiority theory dates back at least to the late

80. *See id*.

81. *See generally* Mark P. Doescher et al., *Racial and Ethnic Disparities in Perceptions of Physician Style and Trust*, 9 ARCH. FAM. MED. 1156 (2000) (discussing African Americans' and other minorities' lack of trust in physicians). A recent study of a "nationally representative sample" shows that African-American and other minority patients, when compared to white patients, "reported less positive perceptions of physicians than whites" on "the summary scales for satisfaction with physician style" and on the "trust in the physician" scale. *Id*. at 1160.

82. In *Dred Scott v. Sandford*, 60 U.S. (19 How.) 393, 404-05 (1856), the United States Supreme Court stated that African Americans "were at that time considered as a subordinate and inferior class of beings, who had been subjugated by the dominant race, and, whether emancipated or not, yet remained subject to their authority, and had no rights or privileges but such as those who held the power and the Government might choose to grant them." *Id.*

1500s when Europeans first came in contact with West Africans during the early days of England's trade expeditions to West Africa.[83] After an initial curiosity with the many different shades of black skin color, English explorers and their countrymen in the late 1500s began to consider black skin color to be unclean and otherwise worse than their own complexion.[84] These explorers frowned upon and labeled West Africans' religious practices as being heathenism.[85] They also gave negative connotations to Africans' alleged savage behavior, including the types of foods they ate, the kinds of clothes they wore, their manner of communication, the number of wives they had, their practice of "cosmetic mutilation," and other cultural behaviors that were different than behavior common in England.[86] These early Englishmen used black Africans' cultural and physical differences as justification for their beliefs that Africans were lower-level beasts.[87]

In furtherance of the beast metaphor, Englishmen had a substantial fixation with Africans' sexual life and created many myths that accentuated and labeled Africans' sexual behavior as being "lewd, lascivious, and wanton."[88] These beliefs included allegations that Africans were overly lustful and beast-like, and that African women had sex with apes.[89] These negative impressions of and feelings toward Africans were probably a psychological projection of the Englishmen's own negative self-images (wants, desires, behaviors, sexual fantasies, and appetite) upon a group of African people who readily supplied the type of different cultural and physical attributes that Englishmen could use to support their argument that they were at least better than the Africans.[90]

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83. WINTHROP D. JORDAN, WHITE OVER BLACK: AMERICAN ATTITUDES TOWARD THE NEGRO, 1550–1812, 4-11 (1968).

84. *Id*. at 7. One scholar asserts that Englishmen considered black skin color to be similar to their general definition of black: "'Deeply stained with dirt; soiled, dirty, foul. . . . Having dark or deadly purposes, malignant; pertaining to or involving death, deadly; baneful, disastrous, sinister. . . . Foul, iniquitous, atrocious, horrible, wicked.'" *Id*. (quoting the Oxford English Dictionary).

85. *See id*. at 20-21.

86. *See id*. at 25-26.

87. *See id.* at 28.

88. JORDAN, *supra* note 83, at 32.

89. *See id*. at 31. Some Englishmen, though probably a minority of them, even believed that Africans descended from apes or apes descended from Africans, and that sex between Africans and apes created other monstrous beasts. *See id*. at 28-32. Along these lines, Englishmen had negative impressions of the naked or skimpy attire that Africans wore and of the polygamy practices of Africans, all which tended to reinforce English notions that Africans were lustful beings. *See id*. at 25. Thus, when combined with Africans' religious practices, Africans' alleged lustfulness and alleged savage behavior reinforced Englishmen's beliefs that Africans were savages. *See id.* Such labels tended to increase the self-image of Englishmen because Africans were a group to which the Englishmen could look upon as being creatures whom they were both different from and better than. *See id*.

90. *See id*. at 40-43.

Consistently, some white Americans have passed down their negative images from one generation to another, starting from colonial times.[91] They have also used the black inferiority theory in a constant effort to lower African Americans' social and economic status. Judge A. Leon Higginbotham, Jr., in *Shades of Freedom: Racial Politics and Presumptions of the American Legal Process*,[92] has extensively discussed the beginning and the continuation of the black inferiority theory from the early colonial period in North America to modern time. In his opinion, the colonists, as a uniting theme, set up black people of African descent as the common foe to whom white people could look to as being inferior.[93] This belief allowed lower class white people to feel good about themselves because they could always view black people as being worse off than white people. This belief in white supremacy, when combined with the possibility that lower class white people could one day become a member of the elite class of white people, minimized the possibility that lower class white people of different ethnic backgrounds would join with black people and protest against the unequal distribution of wealth that the white ruling class controlled.[94]

Persistently, white Americans used this black inferiority theory in colonial America to support state laws that legalized slavery,[95] to establish the legal inferiority of black people[96] and their children,[97] to prevent free black people from holding public office,[98] to prevent interracial marriages,[99] and to prevent

91. *See infra* text accompanying notes 183–93.

92. A. LEON HIGGINBOTHAM, JR., SHADES OF FREEDOM: RACIAL POLITICS AND PRESUMPTIONS OF THE AMERICAN LEGAL PROCESS (1996).

93. *Id.* at 12. One commentator noted that:

> Black slavery provided a floor beneath which no white could fall and laid the foundation for racial solidarity in a society rife with class divisions. As long as any white, no matter how lowly, could look down on the Negro, those class divisions did not seem quite so formidable. Racial unity allowed nonslaveholding whites to treasure their liberty and support slavery.

IRAN BERLIN, SLAVES WITHOUT MASTERS 369 (1975).

94. *See id*. at 10-13. Judge Higginbotham painstakingly discusses the different periods in Virginia during which white people in America (by enacting racially discriminatory laws) institutionalized the black inferiority theory throughout every aspect of human life in America (thereby relegating African Americans to inferior positions in their social, economic, and political lives). He also shows how the Supreme Court, through its restrictive interpretation of the Thirteenth and Fourteenth Amendments, struck down federal laws designed to end discrimination against African Americans and gave federal legitimacy to the "separate but equal" doctrine. *See generally* HIGGINBOTHAM, *supra* note 92 *passim*.

95. *See id*. at 29-30. "The justification of the institution of slavery rested on the innate inferiority theory of black people, their unfitness for freedom, and their incapacity to govern themselves." BERLIN, *supra* note 93, at 369.

96. *See id*. at 32, 47.

97. *See* HIGGINBOTHAM, *supra* note 92, at 32, 35, 47.

98. *Id.* at 172.

the prosecution of slave masters who whipped their slaves to death.[100] The Supreme Court of the United States buttressed the legitimacy of these types of discriminatory state laws by holding in *Dred Scott v. Sandford* that from the beginning, black people have been inferior to white people in America and that they have had only those rights that white people have given them.[101]

Even the South's loss in the Civil War and the subsequent enactment of the Thirteenth, Fourteenth, and Fifteenth Amendments did not dislodge notions of black inferiority. Instead, white people in southern states regained political power through a deal with President Rutherford Hayes that led to the withdrawal of federal troops from southern states after the Civil War.[102] This withdrawal gave southern states the opportunity to enact the infamous Jim Crow laws[103] and Black Codes[104] that virtually re-enslaved African Americans through forced segregation in all aspects of their social and economic lives.[105]

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99. *Id.* at 43.

100. *Id*. at 30, 51.

101. Dred Scott v. Sandford, 60 U.S. (19 How.) 393, 404-05 (1856). *See also* HIGGINBOTHAM, *supra* note 92, at 64 (quoting Dred Scott v. Sandford, 60 U.S. (19 How.) 393, 404-05 (1856), and stating that "[o]n the contrary, [African Americans] were at that time considered as a subordinate and inferior class of beings, who had been subjugated by the dominant race").

102. HIGGINBOTHAM, *supra* note 92, at 91-93.

103. *See id*. at 104, 117. Southern states enacted Jim Crow laws so that white people could maintain white supremacy by segregating and denying equal opportunities to African Americans. *See* Barry C. Feld, *Race Politics, and Juvenile Justice: The Warren Court and the Conservative "Backlash,"* 87 MINN. L. REV. 1447, 1470. The author noted that "[u]ntil the 1960s, law, custom, and extra-legal violence in the South combined to create and enforce a caste system of white supremacy. Blacks were the victims of extreme racial domination through duly enacted "Jim Crow" laws as well as extra-legal violence." *Id.* at 1469-70 (footnotes omitted). Racial prejudice was a motivating factor behind the enactment of these laws. G. Edward White, *The Constitutional Journey of* Marbury v. Madison, 89 VA. L. REV. 1463, 1563 (2003) (asserting that "[t]he legislatures that had passed Jim Crow statutes had been motivated by racial prejudice, and African Americans had systematically been excluded from the legislative process").

However, given that many white people knew that they were descendants of African Americans or otherwise had "black blood" in their bodies, courts did not engage in a rigorous enforcement of Jim Crow segregation laws especially when a white person with "black blood" wanted to pass as a white person. Daniel J. Sharfstein, *The Secret History of Race in the United States*, 112 YALE L.J. 1473, 1504 (2003) (asserting "that many white Southerners had African ancestry and that white communities could function peacefully with that knowledge, whether as family secrets or idle gossip" and that "the courts confronted these realities and generated a body of law that encouraged suits for loss of white racial reputation and discouraged efforts to investigate and uncover individuals' racial backgrounds.").

104. HIGGINBOTHAM, *supra* note 92, at 75, 84-85, 232 n.36.

105. *See id*. at 75. The Hayes–Tilden compromise resulted in Hayes, who lost the majority of the popular votes in the election of 1876, being awarded the majority of the electoral votes in return for his agreement that he would withdraw federal troops from the South. *See* Michael J. Gerhardt, *The Constitution Outside the Courts*, 51 DRAKE L. REV. 775, 787-88 (2003). "Samuel Tilden graciously accepted the commission's vote, while Rutherford B. Hayes agreed to serve

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

As in the past, the Supreme Court, by narrowly interpreting certain laws that Congress enacted under the Thirteenth Amendment (including the Civil Rights Act of 1866[106] and the Civil Rights Act of 1875[107]), was complicit with the southern states in their de jure re-enslavement of African Americans.[108] Consistent with its prior rulings, the Court in *Plessy v. Ferguson* held in 1896 that a state law providing "separate but equal" facilities for white people and for African Americans did not violate the Equal Protection Clause.[109] *Plessy*

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only one term as a means to quiet discontent over the decision. Hayes agreed further to cut a deal with Southern Democrats to end Reconstruction in exchange for their not challenging further the commission decision." *Id.* The withdrawal of the federal troops gave Southern states the opportunity to use violence and the threat of violence to segregate and otherwise take away African Americans' social, economic, and political rights. *See* Jeffrey J. Wallace, *Ideology vs. Reality: The Myth of Equal Opportunity in a Color Blind Society*, 36 AKRON L. REV. 693, 714 (2003) (asserting that "[d]uring the Reconstruction Era and for a short period that ended with the Hayes Tilden Compromise of 1877, African Americans enjoyed some semblance of freedom and equality."). One author reflected:

> In a society born in racism with slavery as its primary means of production a society whose founding documents and principles speak of liberty and equality but simultaneously accommodated the persistence of slavery, a society that fought a bloody civil war in part to attempt to ameliorate the injustices and harms of slavery and then within twenty years sold out its equality aspirations again with the Hayes-Tilden compromise . . . .

Leslie Bender, *Genes, Parents, and Assisted Reproductive Technologies: ARTs, Mistakes, Sex, Race & Law*, 12 COLUM. J. GENDER & L. 1, 66-67 (2003).

106. HIGGINBOTHAM, *supra* note 92, at 75-80. *See* Civil Rights Act of 1866, 39th Cong. 1st Sess. Ch. 31, 14 Stat. 27 (Apr. 9, 1866) (codified as amended at 42 U.S.C. § 1981).

107. 43d Cong. 2d Sess. Ch. 114, 18 Stat. 335 (March 1, 1875).

108. *See* HIGGINBOTHAM, *supra* note 92, at 75-80, 104-07. Regarding the Civil Rights Act of 1866, the Supreme Court upheld certain state laws that prevented African Americans from testifying against white Americans. Regarding the Civil Rights Act of 1875, the Supreme Court made an impermissible distinction between public rights and social rights, holding that racial discrimination in public accommodations were social rights that the Thirteenth Amendment did not outlaw because such discrimination was not a "badge" or "incident" of slavery, nor, according to the Supreme Court, was such unequal provision of public accommodation a violation of the Fourteenth Amendment Equal Protection Clause. *See id.* at 104-07.

109. 163 U.S. 537, 542-43 (1896). One commentator stated:

> It is worth remembering that for some time under the separate but equal doctrines of *Plessy v. Ferguson*, the United States Constitution was interpreted to give comfort and support to racist policies.
>
> The courts must bear a heavy share of the burden of American racism. An outpouring of recent historical scholarship on racism and the American law reveals the outrageous and humiliating extent to which American lawyers, judges, and legislators created, perpetuated, and defended racist American institutions. Legal rules recognized and justified racism. More importantly, legal rules enforced racism by making segregation and the other degradations of racism a legal duty rather than an act of individual free will. In the process they cleared the consciences of white Americans by relieving them of any sense of responsibility for racist practices.

was tantamount to the Court's official recognition of the black inferiority theory, and it gave Southern states the federal legal authority to continue their policies of separating the races in separate, but unequal, public facilities.[110] It was not until approximately fifty-eight years later, after much inhumane discrimination inflicted by white Americans upon African Americans, that the Supreme Court in *Brown v. Board of Education* held in 1954 that the "separate but equal doctrine" violated the Equal Protection Clause of the Fourteenth Amendment.[111] Despite *Brown*, however, southern states frequently continued to practice discrimination, disregarding the Supreme Court's order to end school segregation with "all deliberate speed." These states were intent on furthering the black inferiority theory to the social, economic, and political detriment of African Americans.[112]

Because of the persistent institutionalization of the black inferiority theory, substantial change and opposition against racial discrimination did not occur until the 1960s, when African Americans and supportive white Americans engaged in mass acts of civil disobedience under the leadership of Dr. Martin Luther King, Jr., and many others, including such student leaders as John Lewis, James Bevel, and Diana Nash.[113] These mass demonstrations, including sit-ins at lunch counters, freedom rides throughout Southern states, and the media coverage of these incidents, prodded the administrations of Presidents Kennedy and Johnson into supporting civil rights laws to end racial

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Oliver R. Goodenough, *Biology, Behavior, and Criminal Law: Seeking A Responsible Approach to an Inevitable Interchange*, 22 VT. L. REV. 263, 281 (1997) (footnotes omitted). *See also* Jack F. Trope & Walter R. Echo-Hawk, *The Native American Graves Protection and Repatriation Act: Background and Legislative History*, 24 ARIZ. ST. L.J. 35, 46 (1992) (stating that "[j]ust as racial oppression against African Americans was justified by United States Supreme Court decisions such as *Plessey* [sic] *v. Ferguson*, similar decisions branded Indian Nations as ignorant and uncivilized. . . . [and] 'as an inferior race of people, without privileges of citizens[]'" until a federal court, in 1879, held that "an Indian was a 'person' within the meaning of federal law.") (footnotes omitted); Robert W. Collin & Robin Morris Collin, *Sustainability and Environmental Justice: Is the Future Clean and Black?*, 31 ENVTL. L. REP. 10968, 10968 (2001) (asserting that the legacy of *Plessy* and segregation cause environmental racism where polluting entities are disproportionately located in minority communities and stating that "[t]he footprint of slavery and Jim Crow created much of the current landscape of waste sites and environmental racism.").

110. HIGGINBOTHAM, *supra* note 92, at 117. "In numerous subsequent school cases, state and federal courts continued to approve racial discrimination and segregation; most of the courts or counsel of record in those cases cited or relied upon *Plessy* as support for expansive endorsements of racial subjugation." *Id.*

111. Brown v. Bd. of Educ. of Topeka, Shawnee County, Kan., 347 U.S. 483, 495 (1954).

112. *See* William G. Ross, *Attacks on the Warren Court By State Officials: A Case Study of Why Court-Curbing Movements Fail*, 50 BUFF. L. REV. 483, 492-93 (2002) (discussing how Southern states engaged in strategies to avoid complying with *Brown's* "'all deliberate speed'" for school desegregation).

113. *See generally* JOHN LEWIS & MICHAEL D'ORSO, WALKING WITH THE WIND: A MEMOIR OF THE MOVEMENT (1998).

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

discrimination in public accommodations, in employment, and in voting.[114] These civil rights laws set the foundation for many lawsuits and other legal enforcement actions that have today substantially enhanced African Americans' rights, access to political power, and social and economic status.

Despite the eradication of most public acts of racial discrimination, the black inferiority theory continues to operate in this country today through many acts of covert racial discrimination.[115] In surreptitious ways, it continues to lower the status of African Americans and other minorities, and it otherwise requires that they work twice as hard and be subjected to substantially more frustration, stress, and grief before they can obtain a portion of their rightful share of this country's resources.[116]

Given the historical persistence and present existence of the black inferiority theory and racism, no African American (no matter how successful he or she may be) is totally free, especially when the theory manifests itself through facially-neutral governmental and social policies that allocate educational and economic resources in ways that have a disproportionate impact on African Americans and other minorities, despite an alleged lack of discriminatory intent. This existence of policies with a discriminatory effect is widespread even though the Civil War Amendments, and laws enacted under them, were supposed to outlaw racial discrimination and its harmful effects.

The above discussion of historical racial discrimination through the use of the black inferiority theory is relevant not only to current social, political, and economic discrimination against African Americans and other minorities, but it is also germane to present-day racial discrimination in the health care industry.

B. The Black Inferiority Theory's Impact on the Health Care Profession

If the black inferiority theory has impacted the treatment of African Americans in all aspects of their lives, then it follows that it has had similar harmful effects on African Americans when physicians and hospitals have provided them with medical treatment. The history of medical treatment in this country strongly supports this conclusion.[117]

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114. *See id.*

115. *See, e.g.*, Cheryl L. Wade, *Racial Discrimination and the Relationship Between the Directorial Duty of Care and Corporate Disclosure*, 63 U. PITT. L. REV. 389, 433 (2002) (asserting that "[m]ore often than not, accounts of discrimination in the workplace would depict the kind of covert or unconscious racism that is not easily recognized or acknowledged").

116. *See* Joe R. Feagin et al., *The Many Costs of Discrimination: The Case of Middle-Class African Americans*, 34 IND. L. REV. 1313, 1346 (2001) (discussing the stress that African Americans endure from workplace discrimination).

117. *See* 2 W. MICHAEL BYRD & LINDA A. CLAYTON, AN AMERICAN HEALTH DILEMMA: RACE, MEDICINE, AND HEALTH CARE IN THE UNITED STATES 1900–2000 *passim* (2002) [hereinafter 2 BYRD & CLAYTON] (discussing white physicians' participation in racist medical treatment throughout the history of the United States).

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

Slavery is the beginning point of an analysis that examines the impact of racism on the medical treatment of African Americans. It was during that "Peculiar Institution" that slave masters developed a separate system for African Americans' medical treatment.[118] Under this system, masters provided slaves with medical treatment through a system of "healers" who generally did not have medical training.[119] Some of these healers, known as "root healers," "conjure men," and "midwives," were slaves who treated other slaves.[120] White physicians, with medical training, normally provided treatment to slaves only in extreme circumstances.[121] Furthermore, the treatment that these white physicians provided was frequently of an inferior quality than the treatment that such physicians gave to their white patients.[122] Some of these white physicians had a financial disincentive to provide quality medical treatments to slaves because some slave masters used "practice-by-the-year" contracts, under which white physicians were given a set amount of money to treat designated slaves as frequently as they needed treatment.[123] In addition to providing inferior care to slaves, white physicians also discriminated against free African Americans who did not have access to the inferior care that physicians gave to slaves because white physicians would not treat them.[124]

White physicians during slavery also conducted experimentations on slaves, including operating on them multiple times without anesthesia to perfect "vesicovaginal fistulas and vaginal gynecologic surgery."[125] Some of these physicians used ether experimentally as an anesthesia on slaves, and some of them performed many other unauthorized experiments on slaves. Some physicians even went so far as to purchase slaves for the purpose of performing experiments on them.[126] Some white physicians even used slaves'

118. *See id*. at 12.

119. *See id*.

120. *See id*.

121. *See id*.

122. Larry J. Pittman, *Physician-Assisted Suicide in the Dark Ward: The Intersection of the Thirteenth Amendment and Health Care Treatments Having Disproportionate Impacts on Disfavored Groups*, 28 SETON HALL L. REV. 774, 807-816 (1998) (discussing different types of discrimination in white physicians' treatment of slaves).

123. *Id*. at 811. These treatment contracts caused slaves to receive substandard care because physicians had an incentive to provide them with less care to maximize profits from the lump sum payments that masters would give to physicians for a specified period of time. *See id*. at 811-12.

124. 1 W. MICHAEL BYRD & A. CLAYTON, AN AMERICAN HEALTH DILEMMA: A MEDICAL HISTORY OF AFRICAN AMERICANS AND THE PROBLEM OF RACE: BEGINNINGS TO 1900, at 270 (2000) [hereinafter 1 BYRD & CLAYTON].

125. *Id*. at 271.

126. *Id*. at 270-278 (asserting that Dr. J. Marion Sims, a trailblazer gynecologist, "even purchased one of the women to continue operating upon her").

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

bodies for autopsies, possibly going so far as to rob slaves' graves to obtain corpses for autopsies.[127]

White physicians in the South during slavery were not the only ones to provide racist medical treatments. After the start of the Civil War, many slaves ran away and joined the U.S. Army. Despite their service, these men were not given the same quality of care that white physicians gave white soldiers because many white physicians would not treat African-American soldiers.[128] The U.S. Army and its white physicians also frequently discriminated against the few African-American physicians who were available to treat African-American soldiers.[129] When African-American soldiers did receive medical treatments, it was frequently from physicians who had marginal skills, as they were the only ones who would treat African-American soldiers.[130] One legacy of racist medical treatments during slavery is that the pervasiveness of white physicians' racism (and white peoples' racism in general) created a system in which white physicians, white people, and African Americans came to expect that white physicians would give African Americans a lower quality of medical care than they would give their white patients.[131]

This expectation of an inferior quality of medical treatment for African Americans persisted after slavery was abolished,[132] as white physicians continued their discrimination by refusing to treat free African Americans.[133] These acts of white physicians' racism were supported by racist scientific articles that some white physicians and other authors wrote in an attempt to prove that African Americans were biologically and intellectually inferior to white people.[134] From Reconstruction until the late 1960s, many white physicians openly accepted the notion that it was proper to provide inferior medical treatment to African Americans because they allegedly were biologically inferior. Accordingly, there was no need to provide high quality medical treatment to them because their race would die out on its own because of its allegedly inherent inferiority.[135]

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127. Pittman, *supra* note 122, at 812.

128. 1 BYRD & CLAYTON, *supra* note 124, at 341.

129. *Id.*

130. *Id.*

131. *See id.*

132. *See id*. at 353.

133. 1 BYRD & CLAYTON, *supra* note 124, at 355.

134. *See id*. at 299. Regarding writings of the period that argued that African Americans were inherently inferior, Professors Byrd and Clayton state: "[The influence of these so-called scientific writings] *promoted and promulgated racism within the medical profession and American society that continues even today, at the dawn of the twenty-first century*." *Id*. at 299 (emphasis added).

135. *See id*. at 353.

Given such racist viewpoints, some white physicians would not even provide medical treatments to African-American patients.[136] When white physicians and hospitals did supply treatments to African Americans, they normally provided the treatments in substandard, segregated facilities where the quality of care was inferior to that given to whites.[137] As such, white physicians became complicit in the use of Jim Crow laws to oppress African Americans and otherwise institutionalize the segregation of African-American patients from white patients.[138]

In addition to not wanting to treat African Americans on an equal basis, white physicians and the American Medical Association opposed and discriminated against those African-American physicians who had the capability to receive a medical education despite the substantial racial obstacles that white physicians, and society in general, placed in their paths.[139] For example, from 1870 through the 1960s, white medical societies throughout the United States would not accept African-American physicians as members, despite the fact that many African-American physicians were brilliant and well-trained.[140] Without medical society memberships, African-American physicians could not obtain staff privileges at white-controlled hospitals, could not consult with white specialists, could not obtain malpractice insurance, and could not become members on the staffs at the nation's teaching hospitals.[141]

During this period, some African-American physicians survived only by assuming a second job as either a dentist or other worker to supplement their inadequate incomes from their medical practice.[142] And, it was not uncommon for some white physicians to steal the African-American patients of African-American physicians by convincing such patients that African-American physicians were unqualified.[143] Furthermore, after white physicians assumed control of medical education, they instituted medical school policies that either prohibited many medical schools from accepting African-American medical students or conditioned the acceptance of these students upon an agreement from the students to practice medicine in a foreign country.[144] Even when

136. *Id*. at 355.

137. *Id*. at 355. *See also* Pittman, *supra* note 122, at 814. "[M]any southern white physicians would not treat African Americans unless they paid high fees in advance of treatment, with no possibility of credit from either the physicians or from drug stores." *Id.* at n.159 (citation omitted).

138. 1 BYRD & CLAYTON, *supra* note 124, at 352-53.

139. *See id*. at 384.

140. *Id*. at 399-01.

141. *Id*. at 401.

142. *Id*. at 404.

143. 1 BYRD & CLAYTON, *supra* note 124, at 392, 403.

144. *Id*. at 388.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

African-American medical students were admitted into white medical schools, these schools discriminated against them.[145]

Because many white physicians either would not treat African-American patients or would treat them only on an unequal, segregated basis, two white physicians founded Howard University Medical School and Meharry Medical School. Founded in 1868 and 1876, respectively, these schools were established to train African-American medical students so that African-American patients would have access to African-American physicians.[146] These schools were successful, and as a result white physicians and white medical schools seemed jealous of their success; therefore, the white schools discriminated against white physicians who taught at Howard's medical school.[147] The white establishment also tried to discredit the qualifications of African-American physicians who graduated from these African-American medical schools, in part because it feared the competition for African-American patients that these African-American physicians posed.[148]

This jealousy was all the more problematic given that most white physicians did not believe that African-American patients should receive equal medical treatment. Many believed the scientific racism by accepting the view that African Americans were physically and intellectually inferior to white patients, that African Americans were to blame for their own medical conditions, and that, being the weaker race, African Americans would not survive because of their poor health status.[149]

Relying upon such notions of black inferiority, some white scholars, even as late as the 1960s, reasserted arguments based on the teachings of Social Darwinism and the eugenics movement, alleging that African Americans were genetically inferior to white Americans and that there was nothing that could be done to improve their health status in America.[150] These arguments were in part made to influence governmental policies regarding education, nutrition, and medical assistance for African Americans.[151] Some white physicians used these arguments to further such eugenic policies as forced sterilization, whereby white physicians sterilized a disproportionate number of African-American females as a quid pro quo for the females' reception of welfare and

145. *Id*. at 400. Therefore, despite white physicians' racial discrimination against African-American patients, many of them greedily sought to prevent African-American physicians from making a living as practicing physicians. At least in part, this situation occurred because these white physicians wanted to continue to provide unequal treatment to African-American patients, yet continue to make money treating these patients. *See id*. at 391-92.

146. *Id*. at 387-90, 394-98.

147. *See id.* at 397.

148. *See* 1 BYRD & CLAYTON, *supra* note 124, at 397.

149. *See id*. at 408-09.

150. *See* 2 BYRD & CLAYTON, *supra* note 117, at 430.

151. *Id*.

other benefits.[152] White physicians became involved in this sterilization effort for the purpose of extinguishing the African-American race by taking away African-American women's ability to procreate.[153] Therefore, even when some African-American women had the financial resources to pay for their medical treatments, some white physicians refused to treat their pregnancies unless the women consented to sterilization.[154] Federal and state governmental policies supported these coerced sterilizations, and they were, in part, based upon the notion that African Americans, being the alleged inferior race, should not reproduce.[155]

Physicians and some state governments also used Social Darwinism, eugenics, and general notions of black inferiority as justifications for thousands of non-consensual experimentations on African-American prisoners,[156] and upon the mentally-ill, from 1965 to 1980.[157] White physicians conducted many of these experiments upon African-American prisoners to test drugs and other pharmaceutical products for private drug manufacturers.[158] In addition to testing drugs, some of these white physicians also injected patients with:

> [P]olio, hepatitis, tuberculosis, typhoid, malaria, and cancer cells; performing burn and radiation studies on subject-patients' body parts, testicles, and, occasionally, their entire bodies; feeding them radioactive and other toxic substances; applying and smearing poison, infectious agents, and irritants to their body surfaces; and subjecting volunteers to various powerful hallucinogenic and psychotropic drugs.[159]

Many of these experiments were not for the purpose of treating the victims' medical conditions; rather, they were for the purpose of obtaining medical knowledge that physicians would primarily use to treat white patients.[160] These and other harmful human experiments, using such selection criteria as race, religion, mental capacity, and incarceration, became so

152. *See id.* at 455. Although many white physicians readily sterilized African-American females, they would seldom sterilize young white females of childbearing age, apparently because they knew that large-scale sterilizations would retard the growth of the white population. *See id.* at 458 (quoting ANGELA Y. DAVIS, WOMEN, RACE & CLASS 221 (1981)). Apparently, many white physicians were not very concerned about the genocide of the African-American race; rather, they almost seemed to have wanted such a result. *See id.* at 455, 470-71.

153. *See id.* at 284-85.

154. *See id.* at 455.

155. *See* 2 BYRD & CLAYTON, *supra* note 117, at 452, 455.

156. *See id.* at 461, 469.

157. *Id.* at 468.

158. *See id.* at 470-71.

159. *Id.* at 461. Not only did white physicians subject African Americans to these coerced human experiments, but other powerless Americans, such as military personnel and mental patients, were also subjected to hundreds of experiments in the name of scientific progress. *Id.* at 460.

160. *See* 2 BYRD & CLAYTON, *supra* note 117, at 461.

pervasive that eventually federal governmental agencies passed laws and regulations to guard against such abuses.[161]

Nevertheless, these regulations were not sufficient to prevent the notorious Tuskegee Syphilis Experimentation. This experiment lasted from 1932 until 1972. It was a United States Public Health Service's study of the effects of syphilis on 399 African-American men, many of whom were secretly injected with the virus without their informed consent and without their being given appropriate medical treatments.[162] Many of these African-American men endured years of unnecessary pain and suffering before their deaths, even though penicillin was available to treat their condition.[163] Those who experimented on these men did not do it to treat the men's medical conditions; rather, the experimenters sought medical knowledge regarding syphilis' effects if left untreated.[164] This same type of human experimentation without a therapeutic purpose occurred in a 1972 experiment involving twenty-two African-American women, whom white physicians treated with an unapproved "Super Coil surgical procedure" that subsequently led to some of the women having hysterectomies.[165] The public outcry against the Tuskegee experiment and some of the other experiments led to the enactment of laws and regulations that govern human experimentation.[166]

The importance of the history of racist human experimentation and other discriminatory treatment is that it shows that white physicians have readily adopted Social Darwinist notions and eugenic theories of black inferiority. These physicians have allowed such notions to influence the nature and quality of their treatments of African American and other minority patients.[167] These physicians have played a major role in supporting the racist belief that African-American patients are genetically and intellectually inferior to white patients, and that therefore African Americans require a lower quality of medical treatment.

161. *Id*. at 471-72. In other words, physicians' segregated and inferior medical treatments of African Americans were consistent with the historical theory of black inferiority, and such racist treatments assumed that African Americans "were less than human." *See* Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 AM. J.L. & MED. 203, 211 (2001).

162. King & Wolf, *supra* note 75, at 1027-28 (discussing physicians' discriminatory treatment of African Americans).

163. For a detailed discussion of the Tuskegee Syphilis Study, see JAMES H. JONES, BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT (1993).

164. *See* King & Wolf, *supra* note 75, at 1027.

165. *See* Pittman, *supra* note 122, at 816 (citing Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African-American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191, 202-04 (1996)).

166. *See* 2 BYRD & CLAYTON, *supra* note 117, at 472-73.

167. *See id.* at 474-475.

What this history shows is that white physicians and white hospitals have for hundreds of years been a key force or agent in the perpetuation of harmful and racist medical treatments to African Americans—treatments that have caused many deaths and other negative medical outcomes.[168] Not until the 1960s, with the passage of the Civil Rights Act of 1964[169] and the enactment of the Medicare program in 1965, did substantial desegregation occur in hospitals and in other medical facilities.[170] However, despite these federal laws against racial discrimination, hospitals and physicians still found ways to limit the beneficial effects of desegregation in the health care industry. For example, Medicare financial incentives in July 1996 led to the outward appearance of desegregation in 6,500 (ninety-two percent) of the nation's hospitals.[171] But consistent with the historical ways in which many white Americans have creatively changed rules and procedures to conceal persistent discrimination, white physicians and hospitals employed measures to both desegregate health care facilities and maintain some of the historical racial discrimination in the health care industry.[172] Such procedural changes included hospitals changing double rooms into single rooms so that white patients did not have to be in the same room with African-American patients, hospitals discharging a disproportionate number of white patients into more segregated nursing homes where they did not have to be near African-American patients, and physicians ordering that certain medical treatments take place on an outpatient basis in outpatient facilities where white patients did not have to be near African-American patients.[173]

Although these procedural changes might have been partially motivated by economic reasons and by the evolution of medical treatments, they were also partially motivated by racism.[174] Professor David Barton Smith states:

> The argument here is *not* that racial attitudes were the sole determining cause of all these changes. No single factor can explain why the organization of health in the United States evolved in distinctively different ways than in other

168. *See generally id*. (discussing white physicians' racism and the harmful effects that it has had on African Americans' morbidity and mortality throughout the history of this country).

169. Pub. L. No. 88-352, 78 Stat. 241 (codified as amended at 42 U.S.C. §§ 2000a–2000h-6 (2000)).

170. King & Wolf, *supra* note 75, at 1031. *See also* Watson, *supra* note 164, at 214 (discussing how the Medicare statute's anti-discrimination rule was instrumental in achieving some health care desegregation).

171. Watson, *supra* note 161, at 215.

172. *See* DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 201 (1999) (asserting that African-American patients and other poor patients have experienced an increase in the amount of medical treatments that hospitals and physicians have given them as a result of the Medicare and Medicaid programs, including an increase in the rates of contact with physicians and rate of hospitalizations).

173. *See id*. at 226-33.

174. *See id*. at 228.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

> developed countries. Its evolution reflects the adaptation to a complex combination of pressures. The argument here is that those racial attitudes and concerns helped often subtlety [sic] and indirectly, to reinforce, magnify, and legitimize these changes in use and methods of payment.[175]

Obviously, the above-described organizational changes have assisted in the continuation of a health care system whereby African-American patients and white patients still receive a substantial amount of their medical treatments in a segregated manner.[176]

In addition to the present separation of patients during hospitalizations and other treatments, the medical studies discussed above in Part II (involving racial disparities in heart treatments, cancer treatments, kidney treatments and in many other medical treatments) show that racial discrimination presently exists in the manner in which hospitals and physicians actually give medical treatments to their African-American and other minority patients.[177] This racial discrimination exists despite Title VI and other federal laws that expose those who discriminate, leading to a possible loss of financial resources.[178] It

175. *Id*. Professor Smith acknowledged that historically many hospitals and physicians treated African-American patients even during the period of Jim Crow; however, the medical treatment of African Americans always took place in different rooms at the hospitals or at different times in physicians' offices. *See id*. at 225-26.

176. *See id*. at 226-33. Professor Smith stated: "As the pressures to shorten length of stay increase, as the pressure to do diagnostic and surgical procedures on an ambulatory basis increases, as hospital occupancy drops and competition for a shrinking market share increases, even semiprivate rooms have become de facto private ones. People now recover and die in ever more splendid isolation." *Id*. at 233.

177. *See* Watson, *supra* note 161, at 208 (discussing that Hispanic and Native Americans, despite being qualified and able to afford medical treatment, also receive less treatments than white Americans). In commenting on some of the changes in the patterns of white patients' and African-American patients' medical treatment, Professor Watson has also stated: "Although other factors contributed to this restructuring of American health care, racial bias and selective Title VI enforcement played a significant role." Sidney D. Watson, *Health Care Divided: Race and Healing a Nation*, 21 J. LEGAL MED. 601, 605 (2000) (book review).

178. The rapid "overt" integration of hospitals after the passage of Title VI in 1964, and after the enactment of the Medicare program in 1965, provides evidence that hospitals and physicians will integrate medical services and stop racism in the provision of medical treatments to protect their own financial self-interest when a failure to do so means a loss of funds. *See generally* Watson, *supra* note 161 (asserting that health care payers might be able to end some of the racial disparities in medical treatments by using financial incentives to control physicians' behaviors). Therefore, it is reasonable and desirable that scholars explore the possibility that financial incentives might motivate physicians to change their practices to avoid creating racial disparities in medical treatments. *See id.* However, although such financial incentives may reduce some of the disparities, it is doubtful that such incentives are sufficient enough to eliminate all of the racial discrimination that exists in the health care industry. *See supra* notes 12–81.

First, Title VI's and Medicare's financial incentives have not eliminated covert racial discrimination in the health care industry despite being in existence for approximately thirty

years. This failure is in part shown by the above-referenced studies revealing the many current racial disparities in medical treatments. *See supra* notes 12–81.

Second, some health care purchasers, such as Health Maintenance Organizations ("HMOs") and other managed care plans, probably do not have an incentive to eliminate racial disparities because doing so might increase their costs given that eliminating disparities in treatment would probably mean more treatments for African Americans and other minorities. *See* Randall, *supra* note 10, at 218-19 (arguing that African Americans, as a group, might be sicker than white patients and that, in a managed care regime that seeks to reduce the utilization of medical treatment, African Americans might not be receiving some medically necessary treatment). *See* Watson, *supra* note 161, at 222 (asserting that "[a] managed care plan can have an overall good rating, while disproportionately failing to deliver services to minorities who are likely to be sickest and most in need of care."). Other scholars have noted that managed care organizations' cost-containment procedures might have a disproportionate impact on African Americans and other minorities. *See* Rene Bowser, *Eliminating Racial and Ethnic Disparities in Medical Care*, 30 SUM. BRIEF 25, 26 (2001); Norman L. Cantor and George C. Thomas III, *The Legal Bounds of Physician Conduct Hastening Death*, 48 BUFF. L. REV. 83, 160 (2000); Ellen Wertheimer, *Shakespeare In Law: The Use of History in Shattering Student Credulity*, 45 VILL. L. REV. 463, 470 (2000); Steven P. Wallace et al., *The Consequences of Color-Blind Health Policy for Older Racial and Ethnic Minorities*, 9 STAN. L. & POL'Y REV. 329, 334 (1998); Ezekiel J. Emanuel & Linda L. Emanuel, *Preserving Community in Health Care*, 22 J. HEALTH POL. POL'Y & L. 147, 168 (1997).

Third, employers and other health care purchasers may not be overly concerned with the disparity in treatments because such unequal treatments might result in their paying fewer premiums. To the extent that employers, other health care purchasers, and managed care organizations are influenced by historical notions of black inferiority, these entities might not have the will or desire to force medical providers to give African Americans and other minority patients the same quality of medical care that providers give to white patients whom such entities might consider more deserving of the best medical treatments. Along these lines, it is significant that despite many studies showing racial disparities in medical treatments, neither employers, health care purchasers, nor managed care organizations have publicly disclosed any plans or strategies to prevent racial disparities within their health plans. It is worth noting that African Americans and Hispanics believe, more so than white patients, that insurance companies' and managed care organizations' reimbursement requirements influence their physicians' treatment decisions. *HSC Study Shows Trust In Doctors Remains High*, 17 EMP. ALERT 7, 7 (2000) (finding "[m]ore than half of African-Americans and Hispanics (56% and 54% respectively) agreed that their doctors were influenced by insurance rules, as compared with 40% of whites").

Finally, a multi-faceted approach to ending the racial disparities in medical treatments is needed. This approach appears to be the history of changes in the medical profession. Therefore, this author has no objections to the use of health care purchasers' financial incentives to help alleviate racial disparities in medical treatments. But, even if such financial incentives have some positive effects in reducing health care racism and other racial disparities in medical treatment, they cannot do the job alone. In addition to financial incentives, courts and the health care industry must be willing to embrace tort lawsuits and any other available methods that may assist in eradicating unequal medical treatments. The availability of all methods is especially necessary given that the health care industry (including the organizational structure of medical purchasers and medical providers) is very complex. Therefore, some racial disparities in medical treatment will probably fall through the cracks of any financial incentive systems that health care purchasers use to control the unequal provision of medical treatments, particularly considering the covert nature of much of the racism that is now practiced. One such method to fight the current

appears that physicians and other health care providers are so proficient in their covert discrimination, and enforcers of federal anti-discrimination laws are so inept in their enforcement, that physicians and other providers are not very concerned about being punished for discrimination.

IV. SOLUTIONS TO ERADICATE RACIAL DISPARITIES IN MEDICAL TREATMENTS

A. *The Thirteenth Amendment's Prohibition Against Racial Disparities in Medical Treatment*

1. The Essential Nature of Intentional Racism and Unconscious Racism

When considering direct claims under the Thirteenth Amendment, it is important to note that there are at least two ways in which physicians, hospitals, and other medical providers can give treatments that have a racially disproportionate impact on African Americans and other minorities. First, physicians and hospitals can engage in intentional discrimination for the specific purpose of denying medically necessary treatment to African Americans and others simply because of their race.[179] Second, physicians and hospitals can discriminate through unconscious racism by engaging in a pattern of medical practice that uses stereotypes of African Americans and other minorities to justify giving them different medical treatment than they give to white patients.[180] In most cases, it will be more difficult to prove an intentional discrimination claim. Therefore, an unconscious racism claim (based upon the disproportionate impact that certain facially-neutral policies have on African Americans and other minorities) might be more successful.[181]

A disproportionate impact claim would solve several problems that one might encounter when bringing an intentional discrimination claim. First, a plaintiff would not have to bear the exceedingly onerous task of proving intentional discrimination by medical providers who might be greatly skilled at

racial disparities in health treatments is the use of a direct claim under the Thirteenth Amendment. *See infra* Part IV, A–B.

179. Intentional discrimination was the predominate method of racial discrimination by physicians against African-American patients from the early beginnings until the mid-1960s before the federal government enacted anti-discrimination laws. *See generally* 2 BYRD & CLAYTON, *supra* note 117 (discussing the history of physicians' racial discrimination against African Americans).

180. Since the time of slavery, some physicians have used scientific writings and stereotypes about African Americans' intellectual and physical conditions to justify a belief that they needed to be treated differently than white Americans. *See id.* at 353.

181. A plaintiff alleging discrimination under Title VI and under the Fourteenth Amendment must show intentional discrimination. *See* John Arthur Laufer, Note, Alexander v. Sandoval *and Its Implications for Disparate Impact Regimes*, 102 COLUM. L. REV. 1613, 1614 (2003).

hiding their discrimination.[182] Second, the disproportionate impact claim might be a better means of acknowledging that some of the racial disparities in medical treatment might stem from unconscious racial discrimination.

Professor Charles R. Lawrence's statements about unconscious racism are instructive. He noted:

> Americans share a common historical and cultural heritage in which racism has played and still plays a dominant role. Because of this shared experience, we also inevitably share many ideas, attitudes, and beliefs that attach significance to an individual's race and induce negative feelings and opinions about nonwhites. To the extent that this cultural belief system has influenced all of us, we are all racists. At the same time, most of us are unaware of our racism. We do not recognize the ways in which our cultural experience has influenced our beliefs about race or the occasions on which those beliefs affect our actions. In other words, a large part of the behavior that produces racial discrimination is influenced by unconscious racial motivation.[183]

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182. At least one lesson from hospitals' and physicians' alteration of the methods of providing medical treatments in response to Title VI and to the Medicare program is that medical providers sometimes intentionally take actions that have a disproportionate impact on minorities. This fact is in part shown by many hospitals changing rooms from double occupancy or semi-private to private rooms and by referring more patients to outpatient care instead of inpatient care. *See* Smith, *supra* note 172, at 226-33. Therefore, it is reasonable to believe that some of the racial discrimination that occurs in the health care industry stems from physicians' and other medical providers' intentional racism. Unlike some scholars, this author is not, at this stage, ready to say that acts of unconscious racial prejudice outnumber medical providers' intentional acts of racial discrimination. *See* Geiger, *supra* note 75, at 816. Given that providers' intentional acts of racial discrimination tend to be covert and hard to detect, much of the discrimination that some scholars believe to be unconscious acts of discrimination might in fact be intentional discrimination.

183. Charles R. Lawrence III, *The Id, The Ego, and Equal Protection: Reckoning With Unconscious Racism*, 39 STAN. L. REV. 317, 322 (1987) (footnote omitted). Professor Lawrence identified at least two theories about the origins of unconscious racism. First, he referenced a Freudian psychoanalytic notion of the struggle between the Ego, the rational conscious process, and the Id, the unconscious mind that contains the "desires, wishes, and instincts that strive for gratification." *Id*. at 331. As it relates to racism, the rational Ego tries to conform one's behavior to the predominate public view that racism and discrimination are inappropriate. *See id*. at 331-32. Being under the control of the Ego, the irrational, instinctive Id, normally through "repression," drives its racial stereotyped beliefs about minorities into the unconscious portion of the human psychic. *See id*. However, not to be denied expression, the Id manifests its racist beliefs, through "projection," onto minorities. *See id*. Therefore, a white person who has an Id propensity for being "dirty, lazy, oversexed," and a desire not to control his instinctive, animalistic nature, will, instead of recognizing these "bad traits" in his own personality, project the traits onto African Americans and other minorities so that such minorities will be hated or otherwise stereotyped as having such loathsome traits when, in fact, they may not have the traits. *See id*. at 333-34. Professor Lawrence stated:

> An examination of the beliefs that racially prejudiced people have about out- groups demonstrates their use of other mechanisms observed by both Freudian and nonFreudian [sic] behavioralists. For example, studies have found that racists hold two types of

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

Frequently, unconscious racism mostly stems from the discriminator's projection of his or her own negative traits onto the victim of the discrimination.[184] To explain the negative projection, some have used Freudian theory,[185] cognitive theory,[186] and Carl Jung's collective unconscious theory.[187] Jung asserted that there are several different aspects or "archetypes"

> stereotyped beliefs: They believe the out-group is dirty, lazy, oversexed, and without control of their instincts (a typical accusation against blacks), or they believe the out-group is pushy, ambitious, conniving, and in control of business, money, and industry (a typical accusation against Jews). These two types of accusation correspond to two of the most common types of neurotic conflict: that which arises when an individual cannot master his instinctive drives in a way that fits into rational and socially approved patterns of behavior, and that which arises when an individual cannot live up to the aspirations and standards of his own conscience. Thus, the stereotypical view of blacks implies that their Id, the instinctive part of their psyche, dominates their Ego, the rationally oriented part. The stereotype of the Jew, on the other hand, accuses him of having an overdeveloped Ego. In this way, the racially prejudiced person projects his own conflict into the form of racial stereotypes.

Id. (footnotes omitted).

184. *Id.* at 331-32.

185. *See id*. at 331-36.

186. A second theory of unconscious racism that Professor Lawrence relied upon is the "[c]ognitive approach to unconscious racism." *Id*. at 336-39. This approach recognizes that people normally place other persons into various categories for which they ascribe certain characteristics or stereotypes so that they can make decisions about such persons without having all of the information that a complete evaluation might require. *See id*. at 336-37.

Furthermore, each time an unconscious stereotype affects a child's or adult's behavior, the conclusions derived from the stereotype "progressively intensif[ies] [the] internal stereotypes because [it] reaffirm[s] the perception that members of a certain category are more similar than they actually are and that members of different categories are more dissimilar than they actually are." Deana A. Pollard, *Unconscious Bias and Self-Critical Analysis: The Case For A Qualified Evidentiary Equal Employment Opportunity Privilege*, 74 WASH. L. REV. 913, 919 (1999). Therefore, the cognitive approach theorizes that unconscious racism is a learned behavior that the stereotype-holder automatically uses when he or she comes into contact with a member of a disfavored minority group. Lawrence, *supra* note 183, at 337.

187. A third unconscious racism theory is Carl G. Jung's shadow archetype that is a part of his "collective unconscious" theory, which is described as follows:

> In addition to our immediate consciousness, which is of a thoroughly personal nature and which we believe to be the only empirical psyche (even if we tack on the personal unconscious as an appendix), there exists a second psychic system of a collective, universal, and impersonal nature which is identical in all individuals. This collective unconscious does not develop individually but is inherited. It consists of pre-existent forms, the archetypes, which can only become conscious secondarily and which give definite form to certain psychic contents.

C. G. JUNG, THE ARCHETYPES AND THE COLLECTIVE UNCONSCIOUS 43 (R.F.C. Hull trans., Princeton University Press 2d ed. 1968) (1934). *See also* Lawrence, *supra* note 183, at 323 n.26 (asserting that requiring proof of conscious racism as a prerequisite to constitutional recognition that a decision is race-dependent disregards both the irrationality of racism and its effect on the individual and collective unconscious).

of the human personality, including the shadow.[188] The shadow archetype, the one that appears to be most directly involved in racism, is the dark side of the human personality that consists of one's animal instincts and negative personality traits that frequently exist in one's unconsciousness and that are projected onto disfavored minority groups.[189] In describing this phenomenon, Jung stated:

> In the South, I find what they call sentimental and chivalry and romance to be the covering of cruelty. Cruelty and chivalry are another pair of opposites. The Southerners treat one another very courteously, but they treat the negro as they would treat their own unconscious mind if they knew what was in it. When I see a man in a savage rage with something outside himself I know that he is, in reality, wanting to be savage toward his own unconscious self.[190]

One commentator stated that: "For white people, typically the Shadow appears in a dream as someone who is dark-skinned and considered to be a member of an inferior race. Racism is therefore to a great extent a shadow projection by the dominant group onto members of the subordinated group."[191] Consistently, another scholar has pointed to the interracial sexual relations that many slave masters and other white people, from slavery until the present time, have had with African Americans (females and males) despite white society's general opinions that African-American sex is dirty, animalistic, and otherwise loathsome.[192]

Whether one uses Freudian, cognitive, or Jung's theory, it is clear that some white people have projected certain negative stereotypes onto African Americans and other minorities. Some white physicians are guilty of the same

188. Other parts of the collective unconscious are such archetypes as the persona, the anima and the animus, and the self. CALVIN S. HALL & VERNON J. NORDBY, A PRIMER OF JUNGIAN PSYCHOLOGY 42 (1973).

189. *See id*. 48-51.

190. Dr. Carl Jung, *America Facing Its Most Tragic Moment*, N.Y. TIMES, Sept. 29, 1912, § 5 (Magazine), at 2.

191. Toni Lester, *Protecting the Gender Nonconformist From the Gender Police—Why the Harassment of Gays and Other Gender Nonconformists is a Form of Sex Discrimination in Light of the Supreme Court's Decision in* Oncale v. Sundowner, 29 N.M. L. REV. 89, 115 (1999). *See also* CORNEL WEST, RACE MATTERS 83-91 (1993) (discussing white America's attitude about African-American sex). Professor West stated:

> White fear of black sexuality is a basic ingredient of white racism. And for whites to admit this deep fear even as they try to instill and sustain fear in blacks is to acknowledge a weakness—a weakness that goes down to the bone. Social scientists have long acknowledged that interracial sex and marriage is the most *perceived* source of white fear of black people—just as the repeated castrations of lynched black men cries out for serious psychocultural explanations.

Id. at 86-87.

192. *See id*. at 83-91.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

type of racism.[193] These negative projections are still occurring today, and they contribute to the current racial disparities that exist over a broad range of medical treatments. To help eradicate racial discrimination flowing from such negative projections, this Article advocates a direct claim under the Thirteenth Amendment.

2. The Nature of a Direct Claim Under the Thirteenth Amendment

The current interpretation of the Fourteenth Amendment (and of other civil rights laws) by the Supreme Court and lower-level federal courts requires a showing of intentional discrimination or racial animus to establish a civil claim.[194] Therefore, the Thirteenth Amendment offers the best chance in this country for real social justice, especially considering that many white physicians have mastered the art of covert racism such that they can successfully hide much of their racism and its harmful effects.[195] The Court has left open two questions in its Thirteenth Amendment jurisprudence. First, the Court has not definitively decided whether a private plaintiff can bring a direct claim under the Thirteenth Amendment for acts of racial

193. *See generally*, 2 BYRD & CLAYTON, *supra* note 117 (discussing physicians' use of negative stereotypes to justify giving different treatment to African Americans).

194. Laufer, *supra* note 181, at 1617-18 (asserting that Title VI "bars only demonstrably intentional discrimination, and is in that respect coextensive with the prohibition of the Equal Protection Clause of the Fourteenth Amendment").

195. *See* Wade, *supra* note 115, at 433 (asserting that "[m]ore often than not, accounts of discrimination in the workplace would depict the kind of covert or unconscious racism that is not easily recognized or acknowledged"). Other commentators have recognized that the Thirteenth Amendment itself, without any Section Two legislation from Congress, granted African Americans (and implicitly all Americans) liberty and equal protection of law, which is tantamount to an eradication of the "badges and incidents" of slavery. Baher Azmy, *Unshackling the Thirteenth Amendment: Modern Slavery and a Reconstructed Civil Rights Agenda*, 71 FORDHAM L. Rev. 981, 1007-19 (2002). Azmy asserted that the Amendment "was 'the final step' to full freedom, which included a positive guarantee to all persons the equal enjoyment of all fundamental rights" and that "[i]n addition, the liberty secured by the Thirteenth Amendment included the right to equal protection of the laws of the country." *Id.* at 1013, 1018 (footnotes omitted). *See also* Douglas L. Colbert, *Challenging the Challenge: Thirteenth Amendment as a Prohibition Against the Racial Use of Peremptory Challenges*, 76 CORNELL L. REV. 1, 7 (1990). "This Article argues that one of the thirteenth amendment's [sic] primary objectives was to assure equal justice and universal freedom for African-American people." *Id.* *See also* Jacobus tenBroek, *Thirteenth Amendment to the Constitution of the United States: Consummation to Abolition and Key to the Fourteenth Amendment*, 39 CAL. L. REV. 171, 178-80 (1951) (asserting that Congress' intent in enacting the Thirteenth Amendment was to provide equal protection to African Americans); G. Sidney Buchanan, *The Quest for Freedom: A Legal History of the Thirteenth Amendment*, 12 HOUS. L. REV. 1, 11-12 (1974) (same). For additional scholarly commentary supporting that the Thirteenth Amendment provided for African Americans' natural rights to life, liberty, and the pursuit of happiness, see Pittman, *supra* note 122, at 822-25 nn.209-10.

discrimination.[196] Second, even if a direct claim is available, the Court has not decided whether a disproportionate impact claim is one that can be asserted under the Thirteenth Amendment.[197] This Article argues that the Court should recognize both a direct intentional discrimination claim and a disproportionate impact claim.

Elsewhere this author has argued that the Court, in *Palmer v. Thompson*[198] and in *City of Memphis v. Green*,[199] has implicitly recognized a direct claim under the Thirteenth Amendment, and that the Court's *Bivens*-type civil lawsuits under the Fourth Amendment provide additional support for a direct claim under the Thirteenth Amendment.[200] Given the availability of such a direct claim under the Thirteenth Amendment, the Court has several other major issues to resolve. First, the Court must decide whether Section One of the Thirteenth Amendment, in addition to eradicating the physical enslavement of African Americans on slave plantations, also eradicates the "badges and incidents" of slavery. Section One provides: "Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction."[201]

In the past, the Court has been able to avoid a direct decision on whether the Thirteenth Amendment bans the "badges and incidents" of slavery.[202] However, the Court's decision in the *Civil Rights Cases*[203] presents two justices' opinions on the issue. In that case, Justice Bradley's majority opinion restrictively held that the Amendment bans only the involuntary servitude of African Americans on the plantation and that it conferred only the fundamental rights that Congress sought to protect in the Civil Rights Act of 1866, namely the same rights as white people to "make and enforce contracts, to sue, be parties, give evidence, and to the full and equal benefit of all laws and proceedings for the security of persons *and* property."[204]

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196. *See generally* Jones v. Alfred H. Mayer Co., 392 U.S. 409 (1968).

197. *See generally* City of Memphis v. Green, 451 U.S. 100 (1981).

198. 403 U.S. 217 (1971).

199. 451 U.S. 100 (1981).

200. *See generally* Pittman, *supra* note 122 (discussing the Supreme Court's Thirteenth Amendment jurisprudence). In *Bivens v. Six Unknown Named Agents of Federal Bureau of Narcotics*, 403 U.S. 388, 397-98 (1971), the Court held that a private citizen could file a civil lawsuit directly under the Fourth Amendment to seek damages from federal agents who allegedly searched the citizen's home and arrested him without a warrant. This Article advocates the same type of direct claim for a violation of the Thirteenth Amendment. *See also* Pittman, *supra* note 122, at 853-56.

201. U.S. CONST. amend. XIII, § 1.

202. *See generally* Pittman, *supra* note 122.

203. 109 U.S. 3 (1883).

204. *Id*. at 16 (emphasis added).

On the other hand, Justice Harlan's dissenting opinion in the *Civil Rights Cases* asserted that the Thirteenth Amendment's purpose is to outlaw both the involuntary servitude of African Americans and the "badges and incidents of slavery."[205] He defined "badges and incidents" as any discrimination against

205. *See id*. at 36. Some scholars are of the opinion that a majority of the members of Congress, both those who opposed the Amendment and those who supported it, believed that the Thirteenth Amendment would do more than proscribe the physical confinement of African Americans on slave plantations and involuntary servitude. For example, Professor G. Sidney Buchanan summed up the opponents' position:

> Thus, the main resistance to passage of the thirteenth amendment was based almost entirely on opposition to the expansion and centralization of national power. Most, if not all, elements of congressional opposition asserted that the amendment would guarantee to the emancipated black a basic minimum of rights—equality under the law; protection of life, liberty, and property; opportunity to live, work, and move freely—and that Congress would be empowered to protect these rights. The amendment's opponents clearly recognized its sweeping potential and resisted its adoption, not as the first step in a series of undesirable steps, but as the final step itself.

Buchanan, *supra* note 195, at 9. In support of his opinion, Professor Buchanan, in part, relied upon a statement by Representative William S. Holman, who in opposition to the Thirteenth Amendment, stated:

> But, sir, the amendment goes further. It confers on Congress the power to invade any State to enforce the freedom of the African in war or peace. What is the meaning of all that? Is freedom the simple exemption from personal servitude? No, sir; in the language of America it means the right to participate in government, the freedom for which our fathers resisted the British empire. Mere exemption from servitude is a miserable idea of freedom. A pariah in the State, a subject, but not a citizen, holding any right at the will of the governing power. What is this but slavery? It exists in my own noble State. Then, sir, this amendment has some significance. Your policy, directed in its main purpose to the enfranchisement of a people who have looked with indifference on your struggle, who have given their strength to your enemies, and then the constitutional power to force them into freedom, to citizenship. If such be your purpose, why deceive a noble and confiding people? Your purpose in this amendment is not to increase the efficiency of your Army or to diminish the power of your enemies. No, sir; you diminish the one and increase the other. You run the hazard of all that to gratify your visionary fanaticism, the elevation of the African to the august rights of citizenship.

CONG. GLOBE, 38th Cong., 1st Sess. 2962 (1864) (statement of William S. Holman). Professor Buchanan also relied upon statements from Elijah Ward:

> [W]e are now called upon to sanction a joint resolution to amend the Constitution so that all persons shall be equal under the law, without regard to color, and so that no person shall hereafter be held in bondage.
>
> Sir, it would seem to me that the sum total of the wisdom of the ruling party is contained in the dogma that the negro is exactly like the white man. To some it may seem that this is not very much, hardly enough to constitute the foundation of a political system and an administration policy for a great nation and a numerous people; but this is a matter of opinion.

CONG. GLOBE, 38th Cong., 2d Sess. 177 (1865). *See also* Buchanan, *supra* note 195, at 8.

Professor Buchanan cited several statements from supporters of the Thirteenth Amendment to show that, like the opponents of the Thirteenth Amendment, the supporters

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

believed that it, in addition to breaking the physical bonds of slavery, also guaranteed the equal protection of the freed African Americans and their natural rights to liberty. First, Representative Godlove S. Orth stated:

> The effect of such amendment will be to prohibit slavery in these United States, and be a practical application of that self-evident truth, "that all men are created equal; that they are endowed by their Creator with certain unalienable rights; that among these, are life, liberty, and the pursuit of happiness."

CONG. GLOBE, 38th Cong., 2d Sess. 142 (1865). *See also* Buchanan, *supra* note 195, at 10. Along these lines, Representative Orth also asserted:

> While we remember that it is the constitutional duty of the United States to "guaranty to every State in this Union a republican form of government," let us not forget that the surest and safest way to discharge this duty is to provide proper guards and checks for the protection of individual and social rights in these communities; to keep over them, so long as may be necessary, a guardian watch and care; to remove every opposing element; . . . and last, but not least, to see that the name and spirit of human bondage shall be erased from every State constitution, and personal freedom without distinction assured to every one of their citizens.

CONG. GLOBE, 38th Cong., 2d Sess. 143 (1864).

Therefore, it is clear that some of the opponents and proponents of the Thirteenth Amendment believed that it would provide equal protection to African Americans in their pursuits of life and liberty. Professor Buchanan stated:

> "[T]his then," explained Representative Wilson, "was the slavery which the thirteenth amendment would abolish: The involuntary personal servitude of the Bondsman; the denial to the blacks, bond and free, of their natural rights through the failure of the government to protect them equally; the denial to the whites of their natural and constitutional rights through a similar failure of government." Stated more positively, the thirteenth amendment would free the slave from legal bondage, secure equal protection under the law for all blacks in the exercise of their natural and constitutional rights, and, more pervasively, secure the same equal protection under the law for all United States citizens of whatever race.

Buchanan, *supra* note 195, at 12 (footnote omitted).

Other scholars have concluded that the Thirteenth Amendment proscribes not only physical confinement on plantations but that it also provides for equal protection of African Americans regarding their natural rights to life and liberty. *See generally*, tenBroek, *supra* note 195 (analyzing legislative history to support the conclusion that the Thirteenth Amendment nationalized the equal right of all to enjoy equal protection in those natural rights that constitute that freedom); Pittman, *supra* note 122. For a discussion of one modern application of the Thirteenth Amendment, see Akhil Reed Amar, *The Case of the Missing Amendments:* R.A.V. v. City of St. Paul, 106 HARV. L. REV. 124 (1992) (asserting arguments that the Thirteenth Amendment proscribes such hate speech as cross burning to intimidate African Americans).

As is to be expected, given the extensiveness of the Thirteenth Amendment's legislative history and the politicking that members of Congress engaged in to obtain passage of the Amendment, some of the Thirteenth Amendment's legislative history might be subject to different interpretations. For example, Professor Michael Vorenberg stated the following regarding the Republican supporters of the Amendment:

> For most of the amendment's backers, deflection rather than direct refutation was the preferred method of response to the fearful cry of "negro equality." To keep the amendment from becoming known as an equal rights measure and thus losing the much-

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

> needed support of the Democrats, Republican senators stifled the question of equal rights at every turn.

MICHAEL VORENBERG, FINAL FREEDOM: THE CIVIL WAR, THE ABOLITION OF SLAVERY, AND THE THIRTEENTH AMENDMENT 106 (2001). Regarding Republicans' definition of "equal before the law," Professor Vorenberg states that "[t]his notion of equal treatment, however, rested on a more narrow vision of equality than we are used to today. The Republican notion of 'equal before the law' during this period flowed from free-labor ideology and thus was usually restricted to laws regulating labor." *Id.* at 104.

Some statements by the Republican supporters of the Thirteenth Amendment are confusing. For example, during the Thirteenth Amendment's debate, Senator Timothy Howe of Wisconsin stated:

> And now, Mr. President, what are the apologies for this institution [of slavery]? I have heard them. We hear them daily. That which we hear the oftenest, that which is insisted upon the loudest, is that slaves are only made of negroes or of the descendants of negroes, and that they as a race are inferior to the whites. Whether the fact is so or not, I shall not spend a moment in arguing; but I affirm this, that if in the whole catalogue of excuses that are offered for crimes and offenses, one single excuse could be found more odious than the crime itself, it is this one excuse for slavery. Admit that as a race they are inferior to the race of whites; I ask Senators, I ask me if that is a fact which authorizes you or me to enslave them?

CONG. GLOBE, 38th Cong., 1st Sess. app. 113 (1864).

Arguably, instead of supporting that the Thirteenth Amendment does not provide for the equal protection of African Americans, see VORENBERG, *supra*, at 106, the above quote is more supportive of the position that the alleged inferiority is not reason to enslave them. This interpretation is especially appropriate because other portions of Senator Howe's statement show his opinion that those who are superior should, instead of enslaving the weaker, make the weaker stronger:

> Is it necessary for me to tell the American Senate that the whitest of men are made still a little lower than the angles? And do you think the angles regard that as a reason for binding fetters upon them, for deserting them? Or, on the contrary, is it the reason why they are busy in our behalf to build us up as fast as they can . . . .

CONG. GLOBE, 38th Cong., 1st Sess. app. 113 (1864).

Similarly, Senator John Henderson stated, "So in passing this amendment we do not confer upon the negro the right to vote. We give him no right except his freedom, and leave the rest to the States." CONG. GLOBE, 38th Cong., 1st Sess. 1465 (1864). However, he also noted:

> I will not be intimidated by the fears of negro equality. The negro may possess mental qualities entitling him to a position beyond our present belief. If so, I shall put no obstacle in the way of his elevation. There is nothing in me that despises merit or envies its rewards.

Id. Even though Senator Henderson would have left African-Americans' citizenship and right to vote to state law authority, his statement appears to show that he expected that African Americans would be allowed the merit of their labor, without any obstacles in their paths. *See id.* Implicit in his statement about merit is the notion that equal protection of laws should be provided by the states to ensure that one obtain the merit of his or her labor. Even if Senator Henderson and Senator Howe, however, did not believe in equality and equal protection for African Americans, Professor Buchanan stated that "a majority of members in both the thirty-eighth and thirty-ninth sessions of Congress saw the amendment's legal effect as transcending the abolition of slavery." Buchanan, *supra* note 195, at 10. Professor Buchanan cited Representative E.C. Ingersoll of Illinois for his belief that "the thirteenth amendment would mean 'freedom of speech, . . . the

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

right to proclaim the eternal principles of liberty, truth and justice . . . .'" *Id*. Professor Buchanan further stated "[m]ore over, the thirteenth amendment's adoption would ensure that these rights [of liberty] would receive 'the protection of the [national] government' and the protection of 'equal laws.'" *Id*. at 11.

Therefore, as discussed above, different scholars can disagree about how many members of Congress intended that the Thirteenth Amendment provide some kind of equal protection to African Americans. However, the ascertainment of Congressional intent regarding the Thirteenth Amendment should not depend upon an analysis that counts how many members of Congress were for or against an expansive interpretation of the Thirteenth Amendment, or one that would outlaw the "badges and incidents" of slavery. Rather, the Court should engage in an evolving or dynamic interpretation of the Thirteenth Amendment, one that is more in line with how the Court and Congress have developed the laws and legal interpretations of the Thirteenth Amendment. *Cf.* WILLIAM N. ESKRIDGE, JR., DYNAMIC STATUTORY INTERPRETATION 259 (1994). William Eskridge asserts that:

> [U]nder an "evolutive approach . . . , the Court would overrule a statutory precedent only when the reasoning underlying the precedent has been discredited over time, when the precedent's consequences undermine current statutory policies and legislative purposes, and when practical experience suggests that the statutory goals are better met by a new rule that does not unduly negate public as well as private reliance interests in the old rule.

Id. Applying an evolutive approach to the Court's interpretation of a constitutional provision such as the Thirteenth Amendment means that the Court should interpret the Thirteenth Amendment in light of the current federal policies against racial discrimination and the current recognition that the same black inferiority theory that supported slavery is still the rationale that many white people, privately and publicly, use to justify their present discrimination against African Americans.

An evolving interpretation would have to recognize that both the Court and Congress, despite Congress' intent during the debating and enacting of the Thirteenth Amendment, have concluded that the Thirteenth Amendment did more than cut the physical bonds of slavery. For example, Congress' enactment of the Civil Rights Act of 1866 shows that Congress believed that the Thirteenth Amendment did more than prohibit the confinement of African Americans to slave plantations and involuntary servitude. The Civil Rights Act of 1866, in part, gave African Americans the same rights as white people to "make and enforce contracts, to sue, be parties, and give evidence, to inherit, purchase, lease, sell, hold, and convey real and personal property, and to full and equal benefit of all laws and proceedings for the security of person and property." *See* CONG. GLOBE, 39th Cong., 1st Sess. 474 (1866). Also, it is clear that those who supported the Civil Rights Act of 1866 saw it as a law enacted by Congress under Section Two of the Thirteenth Amendment to enforce the Amendment. In other words, the freedom that the Thirteenth Amendment declared implicitly means that, to be free, African Americans must have more than mere freedom from confinement on plantations. To be free, they must have "liberty," which at least includes the rights that the Civil Rights Act of 1866 granted. tenBroek, *supra* note 195, at 194. In the words of Senator Trumbull, who sponsored the bill, "*I take it that any statute which is not equal to all, and which deprives any citizen of civil rights which are secured to other citizens, is an unjust encroachment upon his liberty; and is, in fact, a badge of servitude which, by the Constitution, is prohibited.*" CONG. GLOBE, 39th Cong., 1st Sess. 474 (1866) (emphasis added). Senator Trumbull's statement is support for the proposition that any law that denies African Americans' liberty because of racial discrimination is a violation of the Thirteenth Amendment, which Senator Trumbull states also outlaws "badge[s] of servitude." *Id*. *See also* tenBroek, *supra* note 195, at 192 n.46 (citing statements of many members of Congress who believed that the Thirteenth Amendment gave "liberty" to African Americans, and that the Civil

Rights Act of 1866 was an exercise of Congress' power to ensure that states do not enact laws that deny African Americans the same civil rights that white people have, as listed in Section One of the Act).

Regarding the scope of the Thirteenth Amendment, proponents of the Civil Rights Act of 1866 believed that the Thirteenth Amendment gave African Americans the natural rights of life, liberty and the pursuit of happiness, and that implicit in that notion of liberty was that there must be an equal protection of laws and rights, at least as far as the rights enumerated in the Civil Rights Act of 1866. *See* tenBroek, *supra* note 195. Therefore, by enacting the Civil Rights Act of 1866, Congress was enforcing the terms of the Thirteenth Amendment itself because under Section Two of the Thirteenth Amendment, Congress' only authority was "to enforce [Section One of the Amendment, which outlaws slavery] by appropriate legislation." U.S. CONST. amend. XIII, § 2. That is, to be a legitimate exercise of Congress' authority under Section Two of the Thirteenth Amendment, the rights listed in the Civil Rights Act of 1866 must have been rights that were encompassed within the scope of the Thirteenth Amendment. In other words, Section One of the Thirteenth Amendment outlaws not only physical slavery (confinement on plantations and involuntary servitude) but all of the "badges and incidents" of slavery that prevent African Americans from enjoying their rights to life, liberty and the pursuit of happiness. In the words of Senator Trumbull: "That is the liberty to which every citizen is entitled; that is the liberty which was intended to be secured by the Declaration of Independence and the Constitution of the United States, originally *and more especially by the Amendment which has recently been adopted* [*the Thirteenth Amendment*]." tenBroek, *supra* note 195, at 191 (quoting Senator Trumbull) (emphasis added).

Furthermore, that the Thirteenth Amendment proscribes more than physical confinement of African Americans to plantations and involuntary servitude is shown by the Court's decision in *Jones v. Mayer*, 392 U.S. 409 (1968). In *Jones*, the Court held that 42 U.S.C § 1982, which proscribes racial discrimination in the sale of real property, was a permissible exercise of congressional power under Section Two of the Thirteenth Amendment. *Id.* at 440 (noting that § 1982 is an updated version of section one of the Civil Rights Act of 1866). Therefore, the Court held that the refusal to sell a home to an African American was an impermissible "badge and incident of slavery." *Id.* at 441.

The importance of *Jones* is that the Court recognized that an act of racial discrimination against an African American was a "badge and incident of slavery," despite the fact that the racial discrimination did not physically confine the African American to a plantation or otherwise subject him to involuntary servitude. *Id.* Although in *Jones*, the issue in question was whether the racial discrimination was a violation of § 1982, which proscribes racial discrimination in the sale of real property, *Jones* is significant because Congress enacted § 1982 under the authority of Section Two of the Thirteenth Amendment. Therefore, a logical conclusion from *Jones* is that Section One of the Thirteenth Amendment, in addition to outlawing physical confinement to slave plantations and involuntary servitude, must also outlaw racial discrimination against African Americans at least as it relates to the sale of real property; otherwise, Congress would not have had the authority under Section Two of the Thirteenth Amendment to enact § 1982.

After *Jones*, the next conclusion that the Court will have to make is to hold that Section One of the Thirteenth Amendment itself outlaws racial discrimination (as a "badge and incident" of slavery) against African Americans and other minorities when the discrimination inhibits such minorities' rights to life, liberty, and the pursuit of happiness. Along these lines, racial discrimination in the health care industry, which some believe causes approximately 60,000 deaths of African Americans each year, most definitely denies liberty and life to many African Americans.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

African Americans that treated them differently than white people because of their alleged inferiority.[206]

Subsequent to the *Civil Rights Cases*, the Court has not decided whether the Thirteenth Amendment itself outlaws "badges and incidents of slavery." For example, in *Jones v. Mayer*,[207] the Court, holding that Congress had the authority under Section Two of the Thirteenth Amendment to define and outlaw "badges and incidents of slavery," did not decide whether the Thirteenth Amendment by itself outlaws "badges and incident of slavery."[208] Similarly, in *Memphis v. Greene*,[209] without holding that the Thirteenth Amendment itself outlaws "badges and incidents of slavery," the Court held that a city's closing of a street through a white neighborhood was not a

206. The Civil Rights Cases, 109 U.S. 3, 36 (1883) (Harlan, J., dissenting). Regarding the scope of the Thirteenth Amendment, Justice Harlan stated:

> The thirteenth amendment, my brethren concede, did something more than to prohibit slavery as an *institution*, resting upon distinctions of race, and upheld by positive law. They admit that it established and decreed universal *civil freedom* throughout the United States . . . .
>
> . . . .
>
> *But I do hold that since slavery, as the court has repeatedly declared, was the moving or principal cause of the adoption of that amendment, and since that institution rested wholly upon the inferiority, as a race, of those held in bondage, their freedom necessarily involved immunity from, and protection against, all discrimination against them, because of their race, in respect of such civil rights as belong to freemen of other races* . . . .
>
> . . . .
>
> What has been said is sufficient to show that power of congress under the thirteenth amendment is not necessarily restricted to legislation against slavery as an institution upheld by positive law, but may be exerted to the extent at least of protecting the race, so liberated, against discrimination, in respect of legal rights belonging to freemen, where such discrimination is based upon race.
>
> . . . .
>
> I am of . . . opinion that such discrimination practised by corporations and individuals in the exercise of their public or quasi-public functions is a badge of servitude, the imposition of which congress may prevent under its power.

Id. at 34, 36-37, 43 (emphasis added in second paragraph).

Subsequently, in *Plessy v. Ferguson*, 163 U.S. 537, 555 (1896), Justice Harlan reiterated his impressions about the scope of the Thirteenth Amendment:

> The thirteenth amendment does not permit the withholding or the deprivation of any right necessarily inhering in freedom. It not only struck down the institution of slavery as previously existing in the United States, but it prevents the imposition of any burdens or disabilities that constitute badges of slavery or servitude.

Id.

207. 392 U.S. 409 (1968).

208. *Id.* at 439.

209. 451 U.S. 100 (1981).

sufficient enough inconvenience to African-American drivers to be a "badge and incident of slavery."[210]

Future litigation will determine the following issues: first, whether the Thirteenth Amendment itself outlaws "badges and incidents of slavery;" second, whether "badges and incidents of slavery" include any act of intentional racial discrimination against African Americans and other minorities that is based upon the black inferiority theory, and that denies African Americans and other minorities the same rights that white Americans enjoy to engage in their fundamental right to life, liberty, and the pursuit of happiness; and third, whether the Thirteenth Amendment outlaws conduct, laws, and practices that have a definite disproportionate impact on African Americans and other minorities despite no specific intent to discriminate. The answer to these questions should be "yes" because all racism against African Americans in this country, whether intentional or unconscious, stem from the same black inferiority theory that supported slavery and post-slavery racial discrimination.[211]

210. *Id.* at 128. The lack of seriousness of the Court's historical treatment of the Thirteenth Amendment is shown by *Palmer v. Thompson*, 403 U.S. 217 (1971). First, the Court apparently entertained the plaintiffs' direct claim under the Thirteenth Amendment. *Id.* In analyzing the claim, the Court noted that plaintiffs' argument was based upon Justice Harlan's dissenting opinion in *Plessy*, which argued that the Thirteenth Amendment also outlaws the "badges and incidents" of slavery, and upon plaintiffs' assertion that the closing of Jackson, Mississippi's swimming pools to prevent African Americans from swimming in the same pools as white people was a "badge and incident" of slavery. *Id.* at 226. In denying the plaintiffs' claim, the Court neither accepted nor rejected the notion that the Thirteenth Amendment itself outlaws "badges and incidents" of slavery, but simply held that the closing of the swimming pool was not odious enough to violate the Thirteenth Amendment. *Id.* at 227. *See also* Pittman, *supra* note 122, at 848-50. Arguably, *Palmer* may mean that there is some level of disproportionate impact that might be odious enough to be a "badge and incident" of slavery.

211. *See* Pittman, *supra* note 122, at 806-07. Although some readers of this Article might lament that the original intent of Congress was not that the Thirteenth Amendment should outlaw racial discrimination against African Americans and other minorities, it is reasonably clear that there is support in the legislative history of the Thirteenth Amendment and the Civil Rights Act of 1866 that some of the proponents and opponents of the amendment and the Act did believe that these laws would provide equal protection to African Americans by outlawing unequal treatment based upon racial discrimination. *See supra* note 205. In any event, the Court's current interpretation of the Thirteenth Amendment should not be controlled by the Court's understanding regarding the original intent of the enacting Congress. Rather, when interpreting the Thirteenth Amendment, the current Court should engage in a "dynamic interpretation" of the Thirteenth Amendment that construes it in light of America's articulated policy against racial discrimination and the devastating effects that present-day racial discrimination has on African Americans and other minorities. *Cf.* William N. Eskridge, Jr., *Some Effects of Identity-Based Social Movements on Constitutional Law in the Twentieth Century*, 100 MICH. L. REV. 2062, 2359-62 (2002). Professor Eskridge makes the following observations regarding the Court's dynamic interpretation of the Fourteenth Amendment in *Brown v. Board of Education* and of its dynamic interpretation of other constitutional provisions in other landmark decisions:

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

> It does not appear that any Justice was persuaded that the framers or ratifiers of the Fourteenth Amendment, on balance, "intended" to render public school segregation constitutionally problematic, and the amendment was not so interpreted in the nineteenth century. In the teeth of historical evidence that educational apartheid was not the object of the Equal Protection Clause, versus moral and social science evidence that such a policy had malignant consequences, the Warren Court emphatically chose the latter and dished off 100 years of history in a couple of sentences. Handed down the same day, *Bolling* interpreted the Fifth Amendment to bar school segregation in the District of Columbia, a result that would never have occurred to the framers of either that amendment (1791) or the Fourteenth (1868). Appropriately, Chief Justice Warren's opinion in *Bolling* made no mention of original intent.
>
> *Brown* and *Bolling* were a watershed. Not only were the briefs strongly presentist in orientation, but the Court's opinions were exclusively so. That the Court's greatest and most legitimate constitutional decisions were rendered with no originalist support—and wide belief that original intent supported *Plessy*—called forth a generation of relatively open constitutional dynamism. An important academic defense of the Living Constitution was penned by then- closeted gay Professor Charles Reich: "[I]n a dynamic society," the Constitution "must keep changing in its application or lose even its original meaning. There is no such thing as a constitutional provision with a static meaning. If it stays the same while other provisions of the Constitution change and society itself changes, the provision will atrophy." After Supreme Court Justices had signaled that they were a ready audience for these arguments, attorneys for people of color, women, and gay people urged the courts in case after case to update the Constitution to protect them from state oppression and to give teeth to their claims of equal citizenship. Not surprisingly, most of the Court's landmark individual rights decisions since *Brown* have ignored original expectations or any meaningful explication of pre-civil rights constitutional history as a basis for their holding. Instead, these decisions have been justified by what general constitutional principles or purposes would seem to require under present social circumstances. Or they have been justified by reference to precedents that themselves updated the Constitution through a present-minded purposivism. These kinds of arguments have been a common feature of Supreme Court decisions selectively incorporating various Bill of Rights provisions into the Due Process Clause (such as *Gideon* . . .); applying the Due Process Clause to strike down vague statutes (such as *Papachristou* . . .); recognizing a right of sexual privacy (such as *Griswold* and *Roe* . . .); sweeping away laws barring sexual and marital relations between people of different races (*Loving* . . .); subjecting sex-based classifications (such as *Craig* . . .) and affirmative action programs (such as *Adarand* . . .) to heightened scrutiny; striking down obsolescent death penalty laws (such as *Furman* and *Coker* . . .); examining state voting restrictions under strict scrutiny (such as the one-person, one vote cases . . .); expanding Congress's power to reach discriminatory conduct . . . and state responsibility for discriminatory acts of private parties (such as the sit-in cases . . .); and protecting people's expressive conduct and association against state censorship (such as the NAACP and Boy Scout cases . . .).

Id. at 2359-61 (footnotes omitted).

Other scholars have recognized that, when interpreting the Constitution, the Court often engages in a dynamic interpretation of constitutional provisions by taking current social and political mores into consideration. Joachim Hermann, *The Death Penalty in Japan: An "Absurd" Punishment*, 67 BROOK. L. REV. 827, 841 (2002). Regarding the Court's belief that the use of the death penalty for persons under fifteen years of age would be contrary to the "social consensus" of decency, the author asserted, "[t]he 'social consensus' argument must, therefore, be taken as

another example of the Supreme Court's dynamic interpretation of the American Constitution rather than as a description of the social reality in America." *Id.*; see also Carol S. Steiker, *Second Thoughts About First Principle*, 107 HARV. L. REV. 820, 825-26 (1994). Steiker noted:

> My argument depends on the acceptance of some version of constitutional dynamism—the principle that interpretations of the Constitution will and should change over time to accommodate the needs of different historical ages. Very few scholars attempt to defend a principle of complete constitutional stasis, by which the Constitution in all of its current applications is to be read exactly as the Framers would have read it, to the best of our reconstruction.

Steiker, *supra*, at 825-26 (footnotes omitted).

The Court's decision in *Lawrence v. Texas*, 123 S. Ct. 2472 (2003), is an excellent example of the Court's use of a dynamic interpretation of the Due Process Clause of the Fourteenth Amendment to hold that Texas' prosecution of two adult males for engaging in homosexual anal intercourse was a violation of the males' liberty interest under the Due Process Clause. *See id.* at 2483-84. Therefore, the Court overruled *Bowers v. Hardwick*, 478 U.S. 186 (1986), which held that the same Due Process Clause did not protect homosexual conduct. *Lawrence*, 123 S. Ct. at 2478, 2483-84. The *Lawrence* Court noted that the history of states' proscription and prosecution of same-sex intercourse between adults was not as clear as the *Bowers* Court had believed, and that only a small number of states prosecuted adults for such conduct. *See id.* at 2478-82. The *Lawrence* Court further noted that in some foreign countries, the governments do not prosecute adults for engaging in homosexual conduct. *See id.* at 2481. Additionally, the Court stated that, along with a weak history of states' prosecutions of same-sex homosexual conduct, the Court's Due Process Clause liberty jurisprudence had undergone a change, in part, through the Court's decisions in *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992) and *Romer v. Evans*, 517 U.S. 620 (1996), such that both married and unmarried persons have more liberty interest rights to make "intimate and personal choices" involving "one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Lawrence*, 123 S. Ct. at 2481 (quoting *Casey*, 505 U.S. at 851).

Therefore, the Court recognized that there was "an emerging awareness that liberty gives substantial protection to adult persons in deciding how to conduct their private lives in matters pertaining to sex." *Id.* at 2474. Acknowledging that emerging awareness, the Court overruled *Bowers*, relying upon its decisions in *Casey* and *Romer* and considering that "[i]n the United States, criticism of *Bowers* has been substantial and continuing, disapproving of its reasoning in all respects . . . ." *Id.* at 2474, 2483-84.

It is unequivocally clear that the Court's decision in *Lawrence* was based upon the Court's dynamic interpretation of the Due Process Clause and of its impact on homosexual conduct. This conclusion is especially true given that the Court gave weight to the current societal attitudes toward homosexual conduct, including the fact that most states do not enforce laws prohibiting such conduct. That the Court engaged in a dynamic interpretation is shown by its statement that:

> Had those who drew and ratified the Due Process Clauses of the Fifth Amendment or the Fourteenth Amendment known the components of liberty in its manifold possibilities, they might have been more specific. They did not presume to have this insight. They knew times can blind us to certain truths and later generations can see that laws once thought necessary and proper in fact serve only to oppress. As the Constitution endures, persons in every generation can invoke its principles in their own search for greater freedom.

Id. at 2484.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

Everyone should know that white Americans enslaved African Americans because they were deemed inferior to white people. Furthermore, everyone should know that after slavery, white people continued to discriminate against African Americans on the grounds that they were allegedly inferior and not worthy of the same rights, privileges and freedom that white people enjoyed.[212] This discrimination by white people against African Americans continued in a *de jure* manner for approximately one hundred years after the Civil War and African Americans' emancipation. The discrimination did not abate until federal laws, and sometimes federal troops, forced integration upon white people during the 1960s.[213] Despite the presence of civil rights laws, however, many white people have continued and will in the future continue their racial discrimination through various overt and covert schemes, as shown by the many lawsuits involving racial discrimination that are discussed in the federal

Similarly, the Court should employ a dynamic interpretation of the Thirteenth Amendment to allow a direct claim under the Thirteenth Amendment as envisioned in this Article. As footnote 205 shows, there is legislative history that the drafters of the Amendment and of the Civil Rights Act of 1866, as well as many of the opponents of those enactments, believed that the Amendment also outlawed the "badges and incidents" of slavery, including any racial discrimination based upon an alleged racial inferiority that denies African Americans, and other minorities, equal protection of the laws and their rights to life, liberty, and happiness in pursuit of the same opportunities that white people have. *See supra* note 205 and accompanying text. To the extent that that legislative history is ambiguous, the Court should refuse to give it overwhelming weight to the same extent that the Court would not rely upon broad statements about how homosexual conduct was broadly frowned upon at the enactment of the Fourteenth Amendment and for many years following the enactment of the Fourteenth Amendment. Instead, the Court should interpret the Thirteenth Amendment, in the tradition of Justice Harlan's dissents in the *Civil Rights Cases* and in *Plessy*, by acknowledging that racism based upon the black inferiority theory was the foundation of slavery and all subsequent acts of racial discrimination. The Court should also consider that private parties commit a substantial amount of current racial discrimination without being subject to a Fourteenth Amendment claim because of the state action requirement. Such private discrimination includes the health care discrimination that is discussed throughout this Article. Additionally, the Court should acknowledge that the current societal norm is that racial discrimination is against the public policy of this country. Finally, the Court should recognize that the Thirteenth Amendment is the only remaining constitutional amendment that proscribes acts of private discrimination. Given these considerations, the Court should construe the Thirteenth Amendment such that the Court holds that the Amendment itself outlaws "badges and incidents" of slavery and that "badges and incidents" of slavery include any act of racial discrimination based upon the black inferiority theory that either denies one the equal protection of the laws or that denies one the same right to life, liberty and happiness that white people enjoy.

212. *See generally* 2 BYRD & CLAYTON, *supra* note 117 (discussing the racist practices of physicians).

213. *See generally* King & Wolf, *supra* note 75 (discussing the racist practices of physicians and how they somewhat abated during the 1960s after the passage of civil rights laws).

reporters and that are now pending before federal civil rights enforcement agencies.[214]

In the health care industry, the continuation of racial discrimination manifests itself in the racial disparities in medical treatments that are the subject of this Article. These racial disparities in medical treatments against African Americans stem from African Americans' alleged status as an inferior race, which is the only conclusion that makes any sense.[215] This same black inferiority theory was the foundation upon which slavery was built.[216] The theory has supported all subsequent acts of racial discrimination against African Americans.[217] Therefore, one should not have to make a giant leap to conclude that the Thirteenth Amendment outlaws any form of racial discrimination that relegates African Americans to an inferior status by denying them the same freedoms that white people enjoy. This conclusion is the essence of Justice Harlan's dissenting opinions in the *Civil Rights Cases* and in *Plessy v. Ferguson*.[218]

Because slavery and racial discrimination in this country were and are based upon the lie that African Americans and other minorities were and are inherently inferior, and because the Court has already held that the Thirteenth Amendment sought to confer on African Americans the same universal freedom that white people enjoy,[219] the Thirteenth Amendment, of necessity, must also outlaw the "badges and incidents" of slavery. To hold otherwise would mean that Congress intended that white Americans should continue to use the black inferiority theory to oppress African Americans even after they were freed from slavery. There is no definitive reason to believe that the

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214. *See* Wade, *supra* note 115, at 395. One commentator stated:

> "[A]s minorities gain entry to the companies that once spurned them, charges of racial harassment on the job have almost doubled, to 6,249 [in 1999] from 3,272 in 1990. . . . The acts cited ranged from slurs to nooses hung in doorways." "The number of victims receiving payouts from employers has tripled, to 1,750 [in 2000] from 513 in 1998." Two glaring examples of the costliness of inadequate corporate responses to racial discrimination grievances are the $176 million settlement of the Texaco litigation in 1996, and Coca-Cola's $192.5 million settlement in 2000.

Id. (alteration in original) (footnotes omitted).

In addition to the employment discrimination that is discussed in this footnote, the discussion in Part II of this Article shows that there are also many acts of racial discrimination that occur today in the health care industry.

215. *See generally* 2 BYRD & CLAYTON, *supra* note 117 (discussing society's and physicians' belief that African Americans were intellectually inferior to white people).

216. *See supra* notes 92–93 and accompanying text.

217. *See generally* HIGGINBOTHAM, *supra* note 92 (discussing the development and progression of the black inferiority theory from one generation to the next).

218. *See supra* note 206 and accompanying text.

219. The Civil Rights Cases, 109 U.S. 3, 20 (1883) (Harlan, J., dissenting). "By its own unaided force and effect it abolished slavery, and established universal freedom . . . . They admit that it established and decreed universal civil freedom throughout the United States." *Id*. at 34.

Congress that enacted the Thirteenth Amendment intended such a result. Federal courts should allow a direct claim under the Thirteenth Amendment to remedy conduct that has a disparate impact on African Americans and conduct that intentionally discriminates against them.[220]

3. The Scope and Impact of a Thirteenth Amendment Claim

Assuming that the Supreme Court does recognize a direct claim under the Thirteenth Amendment, what standards must parties to such a lawsuit meet to establish the claim? Elsewhere, this author has argued that the Court should incorporate the strict scrutiny standard that it established in *City of Richmond v. J.A. Croson Co.*:[221]

> Adopting *Croson's* strict scrutiny standard in the Thirteenth Amendment context would require that, in response to a plaintiff's direct claim of intentional racial discrimination or a plaintiff's prima facie disproportionate impact discrimination claim, a defendant (either a state, private person, or private entity) show that: (1) the challenged practice serves a compelling state or legitimate private interest, (2) the challenged practice is narrowly tailored to the achievement of the asserted interest, and (3) there are no less restrictive alternatives to achieve the asserted interest.[222]

This Article will add further clarification and contours to the Thirteenth Amendment claim.

a. Intentional Discrimination Claims

An intentional discrimination claim is one where a plaintiff alleges that a physician or other health care provider has intentionally discriminated against an African American or other minority when providing medical treatment. For example, assume that a medical provider believes that he or she should discriminate against African-American patients, when deciding whether to recommend the patients for a kidney transplant, because of a shortage of available kidneys. Applying the above-referenced test, a patient should be able to establish her claim by showing that such a physician cannot satisfy this three-part test. The failure to satisfy the first part of the test would be because a physician's racial discrimination against an African-American patient is neither a legitimate private interest nor a legitimate state interest given this country's policy against racial discrimination as announced in the Thirteenth,

220. *See supra* note 205 and accompanying text.

221. 488 U.S. 469 (1989).

222. Pittman, *supra* note 122, at 882. When a private party is involved, the defendant will have to show a "legitimate private interest," which is any interest that is not illegal because such a definition would be most in line with the defendant having the fullest opportunity to pursue his or her life, liberty, and pursuit of happiness. *See id*. at 882 n.412.

Fourteenth, and Fifteenth Amendments and in numerous civil rights laws including Title VI.[223]

Second, it is doubtful that a physician's explicit use of race to ration kidneys would satisfy the "narrowly tailored" requirement because any rationing criteria that discriminate against a particular race because of skin color and notions of black inferiority are not "narrowly tailored to the achievement of the asserted interest" of rationing organs and other medical treatments.[224] Even if the asserted interests (conserving human organs, medical treatments, and physicians' work schedules) were legitimate, a physician's disseminating of medical products and treatments by racial criteria is illogical and irrational for patients who are similarly situated with the same health conditions. Criteria based upon racial discrimination, an illegal social construct, are against the articulated public policy of this country. Therefore, any other legitimate criteria for the dissemination of human organs and medical treatments would be more narrowly tailored than any racial criteria. As such, generally, a physician who intentionally uses racial criteria will not be able to satisfy the second part of the above-referenced test.

Similarly, medical providers who use racial criteria that lead to African Americans and other minorities being given less of or a different type of treatments than similarly-situated white patients should not frequently satisfy the third part of the test—"no less restrictive alternatives to achieve the asserted interest"—because such discrimination would be blatant racism. This

223. Rationing of organs and other medical treatments might be a legitimate public or private interest if there are not enough kidneys to meet the public demand. Some means, including rationing, might be necessary to ensure that a kidney or other organ is put to its best possible use. The same might be true regarding other medical treatments. Therefore, a defendant could conceivably establish the first part of the above-referenced three-part test.

However, a public policy regarding the rationing of organ transplants should be based upon criteria that do not discriminate against either African Americans or other races. Hopefully, the criteria will be such that recipients are either randomly selected or selected based upon real and legitimate race-neutral factors that do not have a disparate impact on any group.

The same analysis and conclusions should apply to other medical treatments, including heart catheterization and other medical procedures for which there is presently a racial disparity between African-American patients and white patients. To the extent that there is no federal policy or procedure for the disbursement of such treatments (for the most part there will not be), and physicians and other medical providers are in charge of providing such treatments, these providers should give medical treatments on either a non-discriminatory basis or refer patients to those medical providers who will give the treatment in a responsible and equitable manner without racial discrimination against African Americans and other patients.

Regarding referrals to other physicians, it is to be understood that some physicians might ration medical care for their own financial self-interest. That is, a surgeon who can physically perform only a certain number of heart catheterization or other cardiac procedures might not be willing to refer patients to another physician because the surgeon can still make some income by keeping the patient and by performing conservative treatments on the patient.

224. *See supra* note 223 and accompanying text.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

conclusion is warranted because it is not legitimate to favor white patients over African-American and other minority patients; only non-racial criteria should be permissible in a country that professes a commitment to racial equality. Therefore, as stated above, any set of non-racial criteria likely would be less restrictive than racial criteria.

In sum, when a patient proves that her medical provider is guilty of intentional racial discrimination because the provider intentionally gave the patient less of or a different type of treatment than the provider gave similarly-situated white patients in the same medical condition, the patient will have established a direct claim under the Thirteenth Amendment because a physician will generally not be able to satisfy the three-part test. However, given sophisticated medical providers' covert discrimination, the complicated nature of medicine, and patients' general lack of knowledge about their medical treatments, many minority patients should consider a disproportionate impact theory of racial discrimination filed directly under the Thirteenth Amendment instead of an intentional discrimination claim.

b. Disproportionate Impact Claim

The above-discussed three-part test also would be applicable to a disproportionate impact claim under the Thirteenth Amendment, but the disproportionate impact claim would require a further discussion of this test that takes into consideration that medical providers generally have more knowledge than their patients about why a patient did not choose or was not offered a certain treatment that providers have disproportionately given to their white patients. Given medical providers' superior knowledge, a patient who brings a disproportionate impact claim under the Thirteenth Amendment should be required to meet the following burden of proof: first, the patient must show that her medical provider did not give her a type of treatment that the provider gave to white patients who were in substantially the same medical condition, and second, that in providing a different treatment to African-American and other minority patients, the medical provider caused a racial disparity in the use of the treatments in that he gave minority patients less of a treatment than he gave white patients, even when the minority patients' medical conditions were substantially the same as white patients' medical conditions.[225] These two factors or elements are the patient's prima facie case,

225. Also, as a general principle of civil procedure and civil lawsuits, the burden of production and persuasion are frequently placed on the party who either has or should have the most information regarding a particular issue. *See* Gomez v. Toledo, 446 U.S. 635, 641 (1980) (discussing that a defendant in a § 1983 case has the burden of persuasion on her good faith defense because, in part, she has access to more information regarding good faith). It seems only reasonable that after a plaintiff has met the requirements necessary to prove her prima facie case (i.e., she has shown that her physician did not give her a treatment that the physician gave to white patients and that there is a racial disparity in the physician's allocation of the treatment), the

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

and they should be sufficient to shift the burden of proof to a defendant medical provider.

The medical provider must then establish the above-referenced three-part test that: "(1) the challenged practice serves a compelling state or legitimate private interest, (2) the challenged practice is narrowly tailored to the achievement of the asserted interest, and (3) there are no less restrictive alternatives to achieve the asserted interest."[226]

In the context of normal medical treatments, an evaluation of a physician's or other medical provider's treatment under the three-part test might be more narrowly focused than would be the analysis of other types of discrimination challenged under a direct Thirteenth Amendment claim. For the first part of the test, in the medical treatment context, the only "legitimate private interest" or state interest that a Court should recognize is the interest of providing medically necessary treatment consistent with the prevailing standard of care.[227] Physicians' and other medical providers' rationing of medical care by using racial criteria is not a legitimate state or private interest.[228]

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physician should have the burden of production and persuasion on the factors at issue in the above-referenced three-part test.

226. *See supra* text accompanying note 222.

227. To provide any treatment to a patient other than medically necessary treatment would be against the physician's fiduciary obligations to treat a patient pursuant to the patient's own best medical interests, without the physician's own self-interests influencing her treatment of the patient. *See generally* Moore v. Regents of the Univ. of Cal., 793 P.2d 479 (Cal. 1990). A physician who secretly allows his or her financial or other interests to influence his or her treatment of a patient runs the risk of being guilty of an informed consent violation. *See id*.

It should be noted that the medical standard of practice is a range of treatments, such as options A, B, or C in the kidney transplant process (see *supra* note 39 and accompanying text) each of which satisfies the standard of care. FURROW ET AL., *supra* note 42, at 172. "Substantial regional variations exist in the use of many procedures, with no apparent differences in outcome . . . ." *Id.* However, to the extent that treatment option C is deemed to be better than option A, physicians should not give more of option C to white people than to African Americans and other minorities. In choosing among the different treatment options, physicians should use non-racial criteria.

To the extent that their alleged race-neutral criteria have a racially disproportionate impact on African Americans and other minorities, physicians (and other challenged medical providers) should have the burden of production and persuasion of offering a non-pretextual reason for the racial disparity, one that is consistent with the obligations that the three-part test, as discussed in the text of this Article, imposes. Similarly, because a physician's or other medical provider's fiduciary duty mandates that such provider treat the individual patient without allowing other patients' health status or concerns to influence the individual patient's medical treatment, physicians and other medical providers should not allow any ideas that they might have about rationing medial care to African Americans, to other minorities, and to white patients to influence the providers' medical judgment about the particular type of medical treatment that should be given to a particular African-American patient, or to any other type of patient. In other words, physicians should provide treatment according to the prevailing standard of medical practice. When physicians give either the treatment that the standard of practice requires or when

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

Regarding the first part of the three-part test, if the defendant physician or other medical provider asserts that "the challenged practice" (giving a different type of treatment to African Americans than to white Americans) serves a legitimate private interest or state interest, the physician or other provider can meet his burden of production and persuasion only by showing that the disparate treatment was medically necessary either because some aspect of the patient's medical condition warranted a different treatment than what the physician disproportionately gave to his white patients or because the patient, after the physician gave her appropriate informed consent disclosure, refused the specific type of treatment that white patients disproportionately chose to accept.[229]

For the second part of the above-referenced test—whether the treatment that caused the racial disparity is "narrowly tailored" to achieve the only legitimate interest of providing medically necessary treatment to the patient—a defendant physician or other medical provider cannot satisfy this standard unless the provider can show that there was no other treatment (that would not have led to a racial disparity in medical treatment or health outcomes) that the patient would have accepted and that would have been just as efficacious as the treatment that the physician did provide.[230] In other words, the medical provider should not be allowed to establish this part of the test if the patient would have chosen the type of treatment that the provider disproportionately provided to his white patients had the medical provider informed her of the existence and availability of the treatment.

Regarding the third part of the test, if the patient would have accepted the treatment that the medical provider disproportionately provided to his white patients, then there would be a less restrictive alternative, namely the treatment that the medical provider gave to the white patients.[231] In the final analysis,

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they give more treatment than the standard of care requires, they should give the treatment in a non-discriminatory manner without any preference for one race of patients over another race of patients.

228. The same is true for medical treatments that have a disproportionate impact on African Americans and other minorities.

229. The trial court and subsequent appellate courts could then scrutinize the physicians' and other medical providers' explanations for the disparity in treatment. Consistent with normal rules of civil procedure, the burden of persuasion is met only when a rational jury could find for the defendant by a preponderance of the evidence that the racial disparity in treatment was medically necessary because of the patient's medical condition or that the patient, after the physician gave appropriate informed consent disclosures, refused the treatment that the physician disproportionately gave to white patients.

230. Normally, the denied treatment would be more effective given that white patients received it when African-Americans did not.

231. If the patient would not have accepted that treatment (after appropriate informed consent disclosures), the physician should still be required to show, in order to meet this part of the three-part test, that there were no other alternative treatments that the patient would have accepted that

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

the bottom line of the defendant provider's burden of production and persuasion is that the provider must offer some evidence that the medical treatments disproportionately given to white patients were either not medically appropriate for the minority patient or that the minority patient refused the treatment after the physician gave appropriate informed consent disclosures.[232]

The above analysis, with its discussion of the three-part test and the shifting of the burden of production and persuasion, is applicable to a patient's claim that a medical provider violated the Thirteenth Amendment when the provider did not give the same type of medically appropriate treatment to the African-American patient or other minority patients as he gave to white patients.[233] This direct Thirteenth Amendment claim is applicable to claims that medical providers did not provide organ transplants and other needed medical procedures, including, but not limited to, such treatments as invasive heart surgery. Additionally, the claim should apply when a minority patient alleges that a physician or other medical provider did not give the patient appropriate informed consent disclosures regarding the patient's options for medical treatments.

V. A NEW APPROACH TO INFORMED CONSENT

Presently, to satisfy their pre-treatment informed consent disclosure obligations, physicians must inform their patients of the risks and benefits involved in the recommended treatment, in alternative treatments, and in no treatment.[234] A majority of the states still have a physician-oriented standard of informed consent whereby a physician must give only those risk disclosures

would not have led to a racial disparity in medical treatment between African-American patients and white patients. Implicit in this notion is medical providers' proof that there is no other treatment that they could have given that would have been as effective as the treatment that they gave to the African-American patient and that the patient would have chosen. Physicians can establish this lack of availability of alternative treatments only if they can show that their informed consent disclosures were complete and that the patient herself chose the given treatment.

232. As argued below, even when the treatment that the physician gave to the white patients was allegedly not medically acceptable or indicated for the African-American patient, the court should still impose an obligation on the treating physician to disclose to the African-American patient the nature of the alleged inappropriate treatment that the physician gave to white patients, the risks involved in the treatment, and the reasons why the treatment is inappropriate. *See infra* Part V.

233. The same test should apply to patients' claims under the Thirteenth Amendment against physicians regardless of the race or ethnicity of the treating physician. *See supra* note 18 and accompanying text.

234. FURROW ET AL., *supra* note 42, at 356-58. Not only must physicians give informed consent disclosures to patients who are seeking medical treatments, physicians and other medical researchers must disclose risk information to patients who are subjects of human experiments and other types of medical research. *See generally* Dana Ziker, *Reviving Informed Consent: Using Risk Perception in Clinical Trials*, 2003 DUKE L. & TECH. REV. 15 (2003).

that are warranted by the prevailing standard of medical practice.[235] This approach can promote a paternalistic standard of medicine because physicians determine the standard of medical practice regarding how much risk disclosure information they must give to their patients.

On the other hand, a slight minority of states has adopted a patient-oriented standard that requires physicians to disclose those risks that would be material to a reasonably prudent patient under the same circumstances.[236] The patient-oriented standard is less paternalistic because the focus is on mandating that physicians and other medical providers disclose material information so that patients can use the information when making decisions about their treatment options—decisions that are consistent with patients' liberty interests in making self-determined decisions about their medical treatments.[237] As such, the patient-oriented standard is more in line with a patient's due process liberty interest in deciding whether to submit to medical treatments.[238]

Considering these notions of patient autonomy, courts and the medical profession should refocus the informed consent doctrine towards an eradication of the current racial disparities in medical treatment. The present informed consent disclosure requirement that physicians must disclose the risks of alternative treatments is ripe for this refocusing. First, as medical treatments generally fall along a spectrum of treatments, where a physician can prescribe several different types of treatments for a given medical condition, physicians should already be informing their minority patients of the specific type of treatments that they are disproportionately giving to white patients.[239] Such an obligation is nothing more than the generally-recognized physician's duty to disclose the risks and benefits of alternative treatments to her patients.

235. FURROW ET AL., *supra* note 42, at 355. *See generally* James A. Bulen, Jr., *Complementary and Alternative Medicine: Ethical and Legal Aspects of Informed Consent to Treatment*, 24 J. LEGAL MED. 331 (2003) (discussing the two approaches to informed consent and stating that the patient-oriented standard is the best approach).

236. Unlike in a physician-oriented jurisdiction, no expert testimony is needed to support an assertion that a certain risk was material because a reasonably prudent jury can decide which risks are material to a reasonably prudent patient. *See id*. at 356.

237. A patient's ability to make informed decisions about the types of medical treatments that she will receive is the ultimate expression of a patient's constitutional and common law rights to determine what shall be done to or with her body. *Cf.* Cruzan v. Mo. Dep't of Health, 497 U.S. 261 (1990) (assuming that a competent adult has a liberty interest in refusing medical treatment).

238. Presently, this author favors the patient-oriented standard for the reasons discussed in the text; however, regardless of whether a state adheres to the physician-oriented standard or the patient-oriented standard, the changes in the informed consent disclosures that this Article proposes should be made. The law and policies surrounding the informed consent doctrine is extensive. *See generally* RUTH R. FADEN ET AL., A HISTORY AND THEORY OF INFORMED CONSENT (1986).

239. *See* FURROW ET AL., *supra* note 42, at 356-58 (discussing the types of risk disclosures that physicians should make to their patients, including the risks of alternative treatments).

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

Therefore, to the extent that physicians are not disclosing the benefits and risks of treatments that they disproportionately give to their white patients, they are already guilty of an informed consent violation that is actionable in a civil lawsuit under the generally-recognized negligence cause of action for failure to provide informed consent disclosures.[240]

It is not unreasonable to believe that many physicians are not giving sufficient disclosures about the risks and benefits of the types of treatments that they are disproportionately offering to their white patients.[241] Therefore, to make physicians' informed consent disclosure obligations more definite in the present environment of rampant racial disparities in medical treatments, the informed consent law should be refined to specifically impose the obligation that physicians do three additional things before providing medical treatment: (1) inform their minority patients that there is a racial disparity between them and white patients regarding the types of treatments that the physician disproportionately provides to white patients; (2) explain the specific reasons why there is a disparity in the treatments among the different races of patients, and (3) explain the specific risks and benefits of the treatments, including, but not limited to, the risks and benefits of the specific treatments that the physician is recommending to minority patients and the specific risks and benefits of the treatments that the physician disproportionately recommends and gives to his or her white patients.

240. *See id.* The informed consent disclosures will be even more important as the medical profession enters such high tech areas as genetic engineering. *See* Harold J. Bursztajn et al., *Protecting Privacy in the Behavioral Genetics Era*, 27 MENTAL & PHYS. DISABILITY L. REP. 523 (2003); Lori Andrews & Erin Shaughnessy, *Ethical, Legal, and Social Issues in Genetic Testing For Complex Genetic Diseases*, 37 VAL. U. L. REV. 793 (2003). A patient's informed consent, and the steps that physicians must take to ensure that they give sufficient information about the risks of medical treatment options, is important and a waiver of a physician's duty to give such information should be scrutinized. *See generally* Jessica Wilen Berg, *Understanding Waiver*, 40 HOUS. L. REV. 281 (2003).

241. Despite the fact that the general duty to disclose the risks and benefits of alternative treatments appears to be clear enough to inform physicians of their disclosure obligations, especially those physicians who act in good faith and with impartiality when they treat their patients, the present disparities in medical treatment probably are because some physicians do not tell their African-American patients that the denied treatment is available. As a matter of fact, many physicians generally do not properly inform their patients about the risks and benefits of their treatment options. *See* James O'Reilly & Amy Dalal, *Off-Label or Out of Bounds? Prescriber and Marketer Liability for Unapproved Uses of FDA-Approved Drugs*, 12 ANNALS HEALTH L. 295, 317 (2003). Despite the importance of informed consent disclosures for a patient's decision-making, many physicians do not disclose material risk information to the patient with sufficient clarity to engender a patient's understanding. *See* Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 948 (1994) (asserting that "[m]any physicians discuss risk in more or less perfunctory manner and without much regard to how well the patient comprehends the information. Many patients appear to understand little of the risk information and, shortly after the discussion, to recall even less.").

Consistent with this Article's argument for a direct claim under the Thirteenth Amendment, the above-recommended changes in the informed consent doctrine are mandated by the Thirteenth Amendment. The proposed changes are required because the Thirteenth Amendment—as defined by Justice Harlan's dissents in the *Civil Rights Cases* and in *Plessy,* and as supported by this Article's arguments—outlaws, as "badges and incidents" of slavery, any racial discrimination against African-American patients and other minority patients that is based upon the black inferiority theory.

Clearly, any physician who recommends and provides treatments to white patients that he or she does not recommend and provide to medically-qualified African Americans and other minorities is practicing medicine pursuant to some version of the black inferiority theory.[242] This conclusion is appropriate because there is no non-racial reason for a physician's refusal to give his or her minority patients the same disclosures of specific risks and benefits of proposed and alternative treatments that the physician gives to his or her white patients. The primary benefit of the proposed additions to the informed consent requirement is that they would give patients the information needed to ask further questions about their medical treatments and to consider the various options for such treatments.[243] This additional information might lead to the patient's acceptance of the treatments that physicians disproportionately make available to white patients. Importantly, the proposed additional disclosures would provide patients with the knowledge that they need to seek a second opinion from another physician who might be more willing to recommend and provide the treatments that physicians disproportionately give to white patients.

In sum, the Thirteenth Amendment is implicated and violated by a physician's failure to give the proposed additional informed consent disclosures. At the very least, a direct claim under the Thirteenth Amendment is appropriate. Further, upon a patient's showing of a racial disparity in medical treatment, the burdens of production and persuasion should shift to the defendant medical provider to offer an explanation for the racial disparity in

242. This conclusion is appropriate because there is no legitimate reason for a physician to provide a different treatment to an African-American patient, who can pay for the same treatment that the physician gives to white patients, unless the patient is not a candidate for the treatment under the prevailing standard of care or unless she refuses the treatment after the physician's appropriate risks and benefits disclosures.

243. The proposed changes to the informed consent requirement should not impose a duty upon patients to ask for relevant risk and benefit disclosures, given that physicians have an affirmative duty to provide such information even if the patient does not ask for it. *See generally* Truman v. Thomas, 611 P.2d 902 (Cal. 1980) (discussing physicians' duty to disclose certain information even if the patient does not ask for it). However, the proposed changes would merely provide a means by which the patient would have more information to discuss her treatment option as a means of self-protection in the event that a treating physician is inclined toward racial discrimination against the patient.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

medical treatment consistent with the above-referenced three-part test, including a discussion of why African-American patients and other minority patients did not receive the same informed consent risk disclosures that white patients received.[244]

VI. CONCLUSION

Although this Article discusses many different aspects of the racial disparities in medical treatment, the fundamental issue that it presents is whether this country will ever recognize the worth of African Americans and other minorities. The current racial disparities, and the concomitant increase in African Americans' morbidity and mortality, cry out for explanations. Given that physicians are in control of the informed consent disclosures and of other discussions during their treatment of patients, it is reasonable that courts should recognize a presumption in favor of impermissible racial discrimination when an African-American patient, or other minority patient, can show a racial disparity regarding her medical treatment in that her physicians gave white patients medical treatments that the physician did not offer to the minority patient. Such a presumption is warranted in light of the persistent racism that has existed in the medical profession, at least from slavery and undoubtedly into the present time. In furtherance of the presumption of racism, a patient should be afforded a direct claim under the Thirteenth Amendment because physicians' racism, being based upon the black inferiority theory, is a "badge and incident" of slavery. Racial disparities in medical treatment, and thus in health outcomes, should be compensable under a direct Thirteenth Amendment claim that would give African-American and other minority patients a cause of action for a physician's intentional racial discrimination, his unconscious racial discrimination that has a disproportionate impact on minority patients, and his failure to obtain a proper informed consent from a minority patient.

244. The same analysis as for an intentional discrimination claim and a disproportionate impact claim (including the plaintiff's prima facie case and the defendant's burdens of production and persuasion) is applicable to a direct Thirteenth Amendment claim alleging a lack of informed consent disclosure for a physician's failure to give the changes that are proposed in this portion of the Article. *See supra* text accompanying notes 221-33.

SAINT LOUIS UNIVERSITY SCHOOL OF LAW