Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities

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RACIAL PROFILING IN HEALTH CARE:
AN INSTITUTIONAL ANALYSIS OF
MEDICAL TREATMENT DISPARITIES

René Bowser*

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Racial profiling is a problem in the United States, and much has been written about the race-based, temporary detention of minorities.\(^1\) Stories and incidents of Black and Latino men being stopped while driving or walking in White neighborhoods because of skin color are so routine that they are no longer news.\(^2\) In fact, the practice of racial profiling is more commonplace than we may realize.\(^3\) This Article suggests that race-based profiling exists in health care and influences providers' clinical judgment.

Researchers increasingly recognize that something has gone terribly wrong in the medical treatment of minority patients. Study after study reveals dramatic disparities in treatment decisions, and recent work confirms that these disparities cannot be explained away by benign factors like economic status, health insurance status, or condition upon presentation.\(^4\)

Ending treatment disparities between Blacks and Whites requires, as a first step, that we understand how those disparities arise. Unfortunately, the health care literature offers no satisfactory explanation. Efforts to understand the reasons for these disparities have focused on psychological, social, and cultural influences such as unspecified patient preferences,\(^5\) overuse of medical treatment by Whites,\(^6\) and unconscious racism.\(^7\) All of these supposed explanations fall short of accounting for the disparities we observe. This Article proposes to fill this gap in the legal and medical literature by offering a more complete theoretical explanation of observed medical treatment disparities—one that yields a variety of specific policy recommendations. The main thesis is that medicine attaches characteristics to particular racial and ethnic groups, and physicians, for a variety of rea-

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4. While logic suggests that similar disparities may affect other cultural and/or ethnic groups, this Article discusses the issue in terms of Black and White, first, because the empirical studies have generally focused on Blacks and, second, because other groups have had a different experience with medicine and biomedical research.

5. See infra Part II.A.

6. See infra Part II.B.

7. See infra Part II.C.
sons, resort to these profiles in making individual treatment decisions. For example, African American patients are understood to be less likely to survive invasive medical procedures, more likely to possess more virulent tumors, and less likely to respond to the standard course of treatment, because of presumed biological differences. From a cultural perspective, African American patients are understood to be less likely to adhere to risky and costly courses of treatment, and less likely to understand their medical condition. To the extent that these profiles influence diagnostic impressions and treatment recommendations, racial disparities in clinical judgment ensue.

The biomedical professions are largely responsible for creating, reproducing, and legitimating these race-based expectations. Within the disciplines of science and medicine, biomedical researchers continue the historical practice of attempting to attribute health differences to race-based biological and cultural differences between Black and White patients. Whether their motives are to reverse the health disadvantages of ethnic minority groups or curiosity about racial and ethnic differences, this race-based research has not discovered the causes and processes of diseases. Instead, race-based research into health differences may paradoxically help to support institutionalized expectations and suspicions within the medical community that unwittingly produce the disparities in treatment that most researchers rightly decry.

This Article links unscientific, race-based medical research to a broader, institutionalized pattern of racial profiling of Blacks in clinical decision-making. Far from providing a solution to the problem of racial health disparities, this Article shows that race-based health research fuels a collection of dubious background assumptions, creates a negative profile of Black patients, and reinforces taken-for-granted knowledge that leads to inferior medical treatment. This form of racial profiling is unjust, and also causes countless unnecessary deaths in the Black population.

8. Unlike other forms of racial profiling, race-based medical profiling suggests the biological or natural inferiority of a particular race or ethnic group. Cf. Gotanda, supra note 3, at 1691.

9. See infra Part V.

10. See infra Part IV.


12. This Article uses the terms Black and African American interchangeably. I capitalize the term Black to emphasize that Blacks, like Asians, Latinos, and other “minorities”, constitute a specific ethnic/cultural group and, therefore, require denotation by a proper noun. See, e.g., Kimberle Williams Crenshaw, Race, Reform, and Retrenchment: Transformation and Legitimating in Antidiscrimination Law, 101 HARV. L. REV. 1331, 1331 n.2 (1988); W.E.B. DuBois, THE SEVENTH SON 12-13 (1971) (noting that the 'N' in Negro had always been capitalized until, in defense of slavery, the use of the lower case 'n' became a custom in “recognition” of Blacks' status as property; and that the capitalization of other ethnic and
This Article is divided into VI sections. Part I provides the most recent evidence that similarly situated Black patients receive different and inferior medical treatment. Part II examines potentially benign explanations for this evidence, and finds them insufficient to account for the existence of racial disparities in medical treatment across numerous medical diagnostic categories and health care settings.

Part III briefly discusses the central tenets of New Institutionalism. New Institutionalism, a genre of organizational sociology, provides the conceptual framework for this analysis. The term "institution" has a distinct technical meaning; it refers to self-perpetuating patterns and practices made in reliance on taken-for-granted background knowledge. Not all institutions are racist. New Institutionalism defines institutional racism as those self-perpetuating patterns and practices made in reliance on taken-for-granted background knowledge about race that serve to lower the status of a particular racial group.

In Part IV, the Article examines the institution of racialized research. As a preliminary matter, it demonstrates that the institution originated within a specific, historical ideology of White supremacy. Second, it suggests that the institution has become self-perpetuating even though the original intent has been lost or forgotten. Third, it suggests that the use of race as a scientific variable constructs Black patients as deviant in relation to the White norm. Finally, it shows how biomedical incentives and norms help to lock-in these understandings, and reinforce the practice of looking for racial differences to explain health differences.

Part V situates these background understandings within the context of clinical decision-making and suggests that physicians rely on them in deciding whether and how to treat a patient of color. Part VI presents a proposal for reinvigorating Title VI enforcement in the area of health care that can potentially eliminate racial profiling in health care.

The remedy this Article suggests is to require each health care entity that receives federal funds to collect and report data on racial disparities in the use of services, as well as the choices of diagnostic and therapeutic alternatives. Existing "report cards" offer a well-established system for data collection; all that is needed is to stratify the reporting by race. This proposal has the obvious advantage of withholding federal funds from institutions that have statistically significant racial disparities. Equally important, it would force institutions to think about race, racial profiling, and medical treatment disparities. Statistics are increasingly being collected to

\[\text{national origin designations made the failure to capitalize the term "Negro" more glaring and insulting.}\]


combat racial profiling in criminal law enforcement, and should also be used to combat profiling in health care. It should be emphasized here that my focus in this Article is on racial disparities in medical treatment—the differences in services that clinically similarly situated White and Black patients receive when seeking medical care. While racial disparities in health status are also influenced by factors other than racial disparities in medical treatment, those treatment disparities that we observe directly implicate issues of racial justice and civil rights and therefore merit their own robust legal and policy response.

I. SEEKING TREATMENT WHILE BLACK: EMPIRICAL Evidence of Racial Discrimination

A growing body of compelling and disturbing evidence points to inferior medical care for similarly situated Black and White patients. Differences in access to quality medical treatment partly explain the existence of higher rates of death from nearly all diseases among Blacks. Much of the evidence is based on “differential treatment” research. To standardize each patient in all aspects, except race, these studies typically employ multivariate analyses to control for confounding variables like insurance status, socio-economic status, education, and medical condition.

Notwithstanding their importance in highlighting racial disparities, most “differential treatment” studies fail to provide any theoretical framework to understand the racial differences. After discussing the methodology and results, the authors typically relegate a discussion of racial

15. See infra note 266.

16. Numerous research indicates that medical care is only modestly important in terms of population-wide health. Indeed, variations in medical spending account for only a small portion of variations in health status. See M. Gregg Bloche, Race and Discretion in American Medicine, 1 YALE J. HEALTH POL’Y L. & ETHICS 95, 97 (2001).

17. Some thoughtful scholars have suggested that focusing on racial bias in therapeutic decision-making potentially diverts public attention and detracts resources from the more important issue of racial disparities in health care that arise from socio-economic disadvantage and the consequently unequal affordability of insurance coverage and medical services. See Bloche, supra note 16, at 97–99. While I am sympathetic to this position, a focus on treatment disparities presents a unique opportunity for beginning a much needed examination of the issue of race and medicine, free from the complicating politics of national health care policy.


19. While the exact significance of these studies of treatment differences as well as some of their methodologies are certainly subject to debate, the studies collectively raise troubling questions about inequities in our health care system that require rigorous exploration.

bias or alternative explanations to a few paragraphs. Further, they give no indication of whether the findings of racial disparity in a particular study represent an isolated example or are indicative of a systemic pattern. As one commentator notes: "Researchers sometimes do not know, forget or are unimpressed that Dante reserved the seventh level of hell for those who recognize a problem and do not attempt to do anything to solve it."\(^2\)

The growing body of research that documents significant disparities in patterns of medical use makes it an increasingly difficult problem to ignore. For example, a review prepared for the American Medical Association's Board of Trustees that was restricted to the literature on treatment disparities appearing only in the New England Journal of Medicine and the Journal of the American Medical Association between 1984 and 1994 filled an alarming sixty-six pages.\(^2\) The work described below was published within the past few years.

### A. The Schulman Study

A 1999 New England Journal of Medicine article features head-and-shoulder pictures of eight “patients” wearing hospital gowns staring straight at the camera.\(^2\) In reality, these were actors, four Black and four White, who described identical symptoms of chest pain. A videotape of them was later shown to 720 physicians who were told that they were participating in a study of clinical decision-making. The investigators, Schulman and others, did not tell the physicians that the primary purpose of the study was to determine the effects of patients’ race (and sex) on clinical decision-making.\(^2\)

The only differences among the “patients” were their race, age and sex. The “patients” followed the same script in describing their symptoms of chest pain, were clothed in an identical manner and given comparable occupations and insurance status. Each doctor was asked to estimate the likelihood that a patient had a narrowing of the coronary arteries and then, based on the results of a stress test, to say whether the patient should be referred to a cardiologist for cardiac catheterization.\(^2\)

For the Black “patients,” Schulman found that the physicians were less likely to refer such patients for catheterization, a costly, state-of-the-

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\(^{24}\) *Id.* at 618–20.

\(^{25}\) *See id.*
art diagnostic measure. Heart disease is the number one killer in the United States, irrespective of "race." Yet, the Schulman study indicates that race independently influences how physicians perceive and manage chest pain.

Additional work demonstrates that racial disparities exist across a spectrum of health care settings and cover a host of diseases.

B. The Provision of Medicare Services

A 1996 study published by a team of investigators affiliated with the Health Care Financing Administration found evidence of racial disparities in the provision of Medicare services. The investigators focused on several medical procedures covered by Medicare, including: hospitalization for ischemic heart disease, coronary-artery bypass surgery, coronary angioplasty, mammography, hip-fracture repair, amputation of a lower limb, and bilateral orchiectomy for prostate cancer.

Physicians treated African American Medicare patients less aggressively, even after controlling for income: Whites were 22% more likely to be hospitalized for ischemic heart disease; 57% more likely to undergo coronary-artery bypass surgery; 49% more likely to undergo coronary


28. By using actors and actual physicians in a controlled environment, the study avoids some of the methodological issues involved in adjusting for confounding variables like income. It also places in doubt some of the more benign explanations for racial disparities in medical treatment. Moreover, the study demonstrates that equality of health care coverage does not guarantee equality of medical treatment. Other work supports the idea that equality of health care does not eliminate racial differences in access. E.g., Emily Friedman, Money Isn't Everything: Nonfinancial Barriers to Access, 271 JAMA 1535 (1994); Vernellia R. Randall, Racist Health Care: Reforming an Unjust Health Care System to Meet the Needs of African Americans, 3 Health Matrix 127 (1993).


30. The authors linked Medicare administrative data concerning hospital discharges with census data to match the zip codes of the Medicare beneficiaries. Next, they assigned a proxy income to each beneficiary that corresponded to the median household income for his or her race and income. In this way, the investigators attempted to control for income, which would allow them to use race as the primary variable to explain differences in the use of health care services. Id. at 792.
angioplasty; 25% more likely to have a mammography; and 57% more likely to undergo hip-fracture repair.\(^{31}\)

The study also found that Blacks were over three times as likely to undergo an amputation for all or part of a lower limb.\(^{32}\) The higher rate of amputation, according to the authors, "suggests that these groups of beneficiaries are at a higher risk for procedures associated with less than optimal management of chronic disease."\(^{33}\) Blacks were also twice as likely to undergo bilateral orchiectomy as a treatment for prostate cancer.\(^{34}\) Bilateral orchiectomy involves the surgical removal of the testicles to treat metastatic prostate cancer.\(^{35}\)

There is also evidence that Blacks are less likely than Whites to receive curative surgery for early-stage lung cancer.\(^{36}\) Once lung cancer has been diagnosed and staged, Black patients are 12.7% less likely to undergo surgical resection than Whites, according to a recent study.\(^{37}\) Notably, the authors of this study concluded that if Black patients were to undergo surgery at a rate equal to Whites, their survival rate would approach that of White patients.\(^{38}\)

Black Medicare patients receive poorer basic care than Whites who are treated for the same illnesses, according to a study by Harvard researchers.\(^{39}\) The study revealed that only 32% of Black pneumonia patients were given antibiotics within six hours of admission, compared with 53%

\(^{31}\) Id. at 797.

\(^{32}\) Id.

\(^{33}\) Id. at 798.

\(^{34}\) Id. at 797.

\(^{35}\) Lower access to primary and preventive care contributes to the differing rates of this advanced form of prostate cancer. See Scott A. Optenberg et al., Race, Treatment, and Long-Term Survival From Prostate Cancer in an Equal-Access Medical Care Delivery System, 274 JAMA 1599, 1604–05 (1995) (explaining that Black and White patients who receive equal treatment exhibit similar survival rates for prostate cancer, after adjusting for stage of disease).

\(^{36}\) Peter B. Bach et al., Racial Differences in the Treatment of Early-Stage Lung Cancer, 341 NEW ENGL. J. MED. 1198 (1999). Non-small-cell cancer is confined to the lung or regional lymph nodes without other metastatic spread. There is agreement that the procedure of surgical resection saves lives in patients with this condition. The authors used Medicare hospitalization records to examine the correlation between having a diagnosis of non-small-cell lung cancer (Stage I or Stage II) and undergoing treatment by surgical resection. The authors controlled for confounding effects such as income, availability of care, and coexisting illness.

\(^{37}\) Id. at 1202.

\(^{38}\) Id.

\(^{39}\) John Z. Ayanian et al., Quality of Care by Race and Gender for Congestive Heart Failure and Pneumonia, 37 MED. CARE 1260 (1999). These researchers assessed the quality of care the patients received by having physician reviewers from each state provide independent assessments of each medical record, and by having a registered nurse from each state examine whether the medical staff had performed certain technical procedures. Id. at 1262.
of White Medicare patients. Also, Blacks with pneumonia were less likely to have blood cultures done during the first two days of hospitalization. The researchers noted that other studies have associated prompt administration of antibiotics and collection of blood cultures with lower death rates.

Blacks who have experienced a heart attack are also less likely to receive inexpensive and effective treatments such as aspirin or a beta blocker drug. Aspirin and beta-blockers are very cheap; both have been shown to reduce death from heart attacks and are considered some of the best medications doctors have available. A 2000 Duke University study confirms these results. It found that Black Medicare patients diagnosed with acute myocardial infarction, "AMI", were less likely to receive low-cost medical therapies recommended in the treatment of AMI. After adjustment for confounding variables like income and insurance status, Black patients were less likely to receive aspirin on admission or beta-blockers on discharge. The authors observed that "[t]he magnitude of racial variation ... suggests that factors such as racial differences in physician recommendations may be involved."

C. Managed Care

As a general matter, managed care appears highly egalitarian and facially neutral in terms of its procedures and practices. Subscribers are entitled to the same package of benefits, choice of physicians, co-payments, appeal rights, and the like, regardless of economic, social, or racial status. Further, managed care's articulated practices of standardizing medical treatments through clinical guidelines and protocols and establishing specific criteria for expensive treatments through utilization review are well-documented. Physician discretion to use factors other than clinical

40. Id. at 1265. Moreover, the Ayanian study found that poor Black patients received a lower quality of care than poor White patients, a finding that strongly suggests that race, not income, is the most significant predictor of variations in quality of care. Id. at 1266.

41. Saif S. Rathore et al., Race, Sex, Poverty, and the Medical Treatment of Acute Myocardial Infarction in the Elderly, 102 CIRCULATION 642, 645 (2000). See also John G. Canto et al., Relation of Race and Sex to the Use of Reperfusion Therapy in Medicare Beneficiaries with Acute Myocardial Infarction, 342 NEW ENG. J. MED. 1094 (2000) (finding that Blacks, regardless of sex, are significantly less likely to receive reperfusion therapy after a heart attack).

42. Rathore, supra note 41, at 646.

43. Medicare beneficiaries enrolled in managed care plans do receive special rights. Ardary v. Aetna Health Plans, 98 F.3d 496 (9th Cir. 1996) (holding Medicare Act does not preempt state tort actions that do not seek payment of Medicare benefits); Grijalva v. Shalala, 946 F. Supp. 747 (D. Ariz 1996) (holding HMO denials of Medicare services constitute “state action” and therefore the due process clause of the Constitution entitles a Medicare beneficiary to a hearing beyond that required by existing statutes and regulations).

44. See generally, MANAGED CARE 3.2.1–3.2.2 (Mark A. Hall & William S. Brebaker III, eds., 1999).
condition are, at least in theory, checked by these presumptively independent means of evaluating whether the treatment decision reached by the attending provider is consistent with, or at least within the acceptable range, relative to the treatment decision that the protocol indicated. Nevertheless, David Carlisle and others at the UCLA School of Medicine reported in 1997 that HMO enrollment does not ameliorate ethnicity-related disparities for Black patients. Focusing on heart disease, the UCLA study examined treatments received by patients hospitalized with a diagnosis of acute myocardial infarction, unstable angina, angina pectoris, or chronic myocardial ischemia. The results conform to findings from other systems of payment, such as Medicare and private insurance. Blacks enrolled in HMOs were 20% less likely than White patients to receive coronary angiography, 35% less likely to undergo heart bypass surgery, and 40% less likely to undergo coronary angioplasty. Carlisle concluded that bias in clinical decision-making may play a role in explaining these disparities. Equally important, he observed that "increased reliance on ... HMOs, particularly among African Americans, may not eliminate ethnicity-related disparities in the use of expensive, high-technology medical services."

Further, preliminary evidence suggests that Black patients are more likely to be denied authorization by their primary care physician to see a specialist, even after adjusting for severity of symptoms. This finding raises substantial concerns about the equity with which gatekeeping is practiced. Collectively, this work suggests that the legal and organizational change from one system of health care, fee-for-service, to another, managed care, does not eliminate practices and patterns of behavior that have a negative impact on people of color.

45. See id. In practice, however, empirical uncertainty about the outcomes of most medical interventions undermines the use of practice guidelines as a means of controlling physician discretion. Bloche, supra note 16, at 101.

46. David M. Carlisle et al., Racial and Ethnic Disparities in the Use of Cardiovascular Procedures: Associations with Type of Health Insurance, 87 AM. J. PUB. HEALTH 263 (1997). The results were adjusted for primary diagnosis, among other things, to ensure that Black patients admitted for, say, chest pain were not compared with White patients admitted for more serious conditions. Id. at 263–64.

47. Id.

48. Id. at 265.

49. Id. at 266.


51. The evidence of racial bias in managed care becomes especially important when one considers the concerns expressed by Black physicians that they have been denied managed care contracts because of race. The potential for exclusion in the physician selection process is heightened by the criteria managed care plans use in their selection decisions. Under economic profiling, the consumption of medical resources is often
In a 1999 study, researchers in New York evaluated the medical records of 4,905 patients who underwent a coronary angiography during hospitalization. Of the original patients who had undergone an angiography, the researchers identified 1,261 for whom coronary artery bypass surgery (CABG) was deemed “necessary” and “appropriate,” based on criteria developed by the Rand Corporation. The purpose of the study was to determine whether there were race and gender differences in the underutilization of coronary artery bypass surgery among patients for whom this procedure was the appropriate intervention.

The differences were significant. After controlling for age and insurance status, Black patients were found to be only 64% as likely to receive surgery as Whites. The gender disparity was much smaller; White women were 94% as likely to receive the surgery as White males.

Care of HIV-infected adults also differs by race. Even though HIV has become a highly treatable disease, Black patients are less likely to receive antiretroviral therapy or preventive treatment for opportunistic tracked as part of the managed care physician evaluation process. Black physicians, in particular, tend to work in solo practices and tend to have sicker patients, two cost-increasing factors that potentially make them less attractive to managed care plans. The National Medical Association, which speaks for the nation’s 20,000 Black physicians, has made the managed care selection issue one of its top priorities. As a consequence of the exclusion of Black physicians, patients of color may have to drop their neighborhood Black physicians when they join a managed care plan and may have to travel to find another one in their plan, assuming they can find one. Patients on Medicaid and those enrolled in a Medicare HMO face the problem most frequently. They often have no transportation to reach a distant Black doctor. Also, they are randomly assigned to physicians if they fail to choose one on their own. E.g., Risa Lavizzo-Mourey et al., The Perceptions of African American Physicians Concerning Their Treatment by Managed Care Organizations, 88 J. NAT’L MED. Ass’n 210 (1996). In 1996, National Public Radio featured minority physicians who suspected that they had been denied managed care contracts because of their race. All Things Considered (National Public Radio radio broadcast, Nov. 14, 1996).


53. Id. at 69.

54. Id. at 74. For patients for whom CABG was deemed necessary by the Rand criteria but not performed, the New York team attempted to contact the cardiologists to ask why the procedure had not been performed. The most common reason physicians gave for not recommending surgery was “coronary anatomy.” This response is puzzling. As the researchers indicate, nearly all of the patients had left main disease, three vessel disease, or two vessel disease, all indicators of surgical appropriateness. The authors indicate that coronary unsuitability could be interpreted to mean the existence of distal or diffuse disease or small vessels that cannot be bypassed. There is nothing in the study to indicate that Black patients possess these characteristics at a greater rate than Whites. Id. at 75–76.
These treatment disparities “cannot be explained by other characteristics of these patients” such as income or insurance status.56

Other studies demonstrate that Black patients are significantly less likely to receive pain medication despite similar complaints of pain. Emory University researchers found that Black patients were significantly less likely to receive analgesics than other emergency room patients presenting with new, isolated long-bone fractures.57 This finding is consistent with studies that have shown a disparity in the treatment of pain in minority cancer patients. For instance, Cleeland et al. found that 65% of Black patients did not receive guideline-recommended analgesic prescriptions compared with 50% of non-Black patients.58

Racial disparities are most pronounced in the use of moderate and high discretion procedures. In one study, investigators obtained hospital discharge data for all Massachusetts residents, identified 10 clinically important surgical procedures, and designated each procedure as low, moderate, or high discretion.59 Their findings showed lower rates of the use of moderate and high discretion procedures among Black patients. For instance, Black patients had a lower rate for the moderate discretionary procedure of carotid endarterectomy,60 even though Blacks have a higher rate of stroke and cerebrovascular death than Whites and the procedure would greatly reduce fatalities from these conditions.61 The authors concluded that when there is clinical uncertainty about the benefits of a procedure, Whites are generally more likely to undergo those major surgical procedures than Blacks.62

This brief review of recent work demonstrates that Black patients systematically receive less medical treatment than similarly situated White patients. The disparities in medical treatment between Blacks and Whites

55. Martin F. Shapiro et al., Variations in the Care of HIV-Infected Adults in the United States: Results from the HIV Cost and Services Utilization Study, 281 JAMA 2305, 2314 (1999).
56. Id.
57. Knox H. Todd et al., Ethnicity and Analgesic Practice, 35 ANNAES EMERGENCY MED. 11 (2000). The study reviewed emergency department discharge records and identified all Black and White patients discharged with a diagnosis of long-bone fracture. The disparity in pain medicine administration (74% vs. 57%) existed after controlling for potential confounding variables such as time since injury, total time in the emergency department, shift of presentation, need for fracture reduction and payer status. Moreover, the risk of receiving no analgesic while in the emergency department was 66% greater for Black patients. Id. at 12–14.
60. This procedure is explained in detail in footnote 73.
61. Mort et al., supra note 59, at 765.
62. Id. at 763.
have been estimated to result in at least 60,000 excess deaths in the Black population annually.\textsuperscript{63}

These findings pose an important question for health law scholars: are racial differences in medical treatment the result of racial bias? Some medical ethicists suggest that “racism remains the presumptive cause of... the health care problems minorities face” until there is evidence to the contrary.\textsuperscript{64} The American Medical Association has similarly attributed medical treatment disparities, in part, to racial bias.\textsuperscript{65} Others insist on the colorblindness of medicine. Sally Satel, for instance, argues that the Hippocratic ideal of the physician as the honorable agent of the patient is conscientiously followed and that we should feel comfortable that medical treatment decisions are objective and free from the influence of irrational factors like race.\textsuperscript{66}

II. Poverty of Existing Explanations of Racial Disparity

This section analyzes the three most common alternative explanations for racial disparities in treatment—patient preferences, overuse by Whites, and unconscious racism. It concludes that the available evidence in support of these explanations is insufficient to exclude institutional racism and racial profiling as the primary explanations for the observed racial differences. Even so, the issue of racial bias cannot be resolved in the abstract. History, ideology and institutions all matter in this narrative.\textsuperscript{67}

\textsuperscript{63} Charles DeShazer, M.D., Letter to the Editor, 342 NEW ENG. J. MED. 518 (2000). DeShazer suggests that the magnitude of the problem is illustrated by comparing this figure with the 58,000 deaths that occurred over a 10-year period during the Vietnam War.

\textsuperscript{64} Leslie Pickering Francis, Affirmative Action and the Allocation of Health Care, 66 MOUNT SINAI J. MED. 241 (1999).

\textsuperscript{65} Deborah Shelton, A Study in Black and White, AM. MED. NEWS, May 1, 2000, at 22. Moreover, the American Medical Association’s Council on Ethical and Judicial Affairs has acknowledged the existence of racial bias:

Because racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race, physicians should examine their own practices to ensure the inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue.


\textsuperscript{66} SALLY SATEL, PC M.D.: How POLITICAL CORRECTNESS IS CORRUPTING MEDICINE 155 (2000). Moreover, she makes the much stronger assertion that claims of racial bias mainly reflect the contemporary zeitgeist that attributes any race-related difference in social outcome to racism. Id. at 157.

\textsuperscript{67} Recent work by several scholars shows that the ideology of White supremacy plays a central, outcome-determinative role in the development of social institutions that
A. Cultural Preferences

Uncomplicated by the mediating roles of income, education, insurance status and the like, some investigators explain the residual disparity in treatment by speculating that Blacks and Whites may differ in their treatment preferences, with White patients “preferring” more services than Blacks. This argument suggests that the decision to undergo a high technological procedure is influenced by the patient’s “perceived risks and benefits of the procedure and other factors, such as one’s trust in medical approaches involving advanced forms of high technology.” These factors presumably differ by race.

Not much evidence supports this claim. Most of those who advance the patient preferences theory rely on the frequently cited Coronary

perpetuate racial discrimination. These institutions become self-reinforcing, regardless of the conscious or unconscious intent of current actors working within those institutions. See, e.g., Daria Roithmayr, Barriers to Entry: A Market Lock-in Model of Discrimination, 86 Va. L. Rev. 727 (2000) (arguing that anticompetitive conduct by Whites in the legal profession both created an overwhelming initial advantage for Whites and developed a standard that favors White cultural performances and disproportionately excludes people of color); Richard T. Ford, Geography and Sovereignty: Jurisdictional Formation and Racial Segregation, 49 Stan. L. Rev. 1365 (1997) (suggesting that segregation played a central evolutionary role in creating racialized housing patterns that have become self-reinforcing).

68. See, e.g., Mark B. Wenneker & Arnold M. Epstein, Racial Inequalities in the Use of Procedures for Patients with Ischemic Heart Disease in Massachusetts, 262 JAMA 253, 256 (1989) (“Another explanation relates to socio-cultural differences between Blacks and Whites and related preferences for different sorts of medical care. These may be true interracial differences or, in some instances, may merely reflect differences between different socio-economic classes.”); Edward Hannan et al., Interracial Access to Selected Cardiac Procedures for Patients Hospitalized with Coronary Artery Disease in New York State, 29 Med. Care 430, 440 (1991) (“A second possible explanation for interracial access differences is that Blacks refuse recommended surgery more often than Whites. There is some evidence of this phenomenon, but more studies should be conducted.”) (citation omitted); Charles Maynard et al., Characteristics of Black Patients Admitted to Coronary Care Units in Metropolitan Seattle: Results from the Myocardial Infarction Triage and Intervention Registry, 67 Am. J. Cardiology 18, 21 (1991) (“Factors such as patient preference may account for the racial difference.”); 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, 625 (1993) (“Possible explanations include cultural differences in attitudes toward procedures or medical care in general.”); If Blacks are less likely than Whites to accept recommendations that they undergo invasive procedures, this reluctance might be greater for CABG and PTCA than for cardia
catheterization. Alternatively, [W]hites may be more likely to expect that these procedures will be part of their care.”).

69. 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 authors found that the differences are real and do matter. A study of 12,402 patients at Duke University Medical Center found that “Blacks with coronary disease were significantly less likely than Whites to undergo coronary revascularization, particularly bypass surgery; a difference that could not be explained by the clinical features of their disease.” Id. at 480.
That study revealed that of those patients whom physicians recommended for coronary artery bypass surgery, Whites were 13% more likely to receive the surgery. The inference is that Black patients who were recommended for surgery declined the surgery because of their “preferences.” The study does not, however, state that Black patients expressly refused the surgery. Obviously, there are a host of reasons that could explain the difference, including insurance status and income, factors for which the study did not adjust.

As part of a study of the four-fold racial difference in the use of carotid endarterectomy, a 1998 study evaluated the explanatory role of racial preferences. Based on a small sample of patients hospitalized for stroke or ischemic attack (44 Blacks and 46 Whites), the researchers found a “highly significant racial difference in patients’ attitudes toward receiving carotid endarterectomy, a surgery proven to reduce the chance of experiencing a future stroke.” Notably, however, more of the Black patients had already experienced a stroke compared to their White counterparts (75% versus 33%). With this in mind, the researchers conceded that the findings of different racial preferences could be misleading because the Black patients possibly felt they had less to gain from the procedure than White patients who had not yet experienced a stroke.

In contrast, Harvard researchers reported a racial disparity in access to kidney transplantation and rejected the hypothesis that this disparity was the result of patient preferences. The study revealed that in contrast

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71. Id. at 1446-48.
72. Id.
73. This procedure opens arteries in the neck whose branches supply the head and neck. Carotid endarterectomy is different from most surgical procedures because it reduces the future risk of stroke, as opposed to other surgeries that reduce current suffering. See Marc R. Mayberg et al., Carotid Endarterectomy and Prevention of Cerebral Ischemia in Symptomatic Carotid Stenosis, 266 JAMA 3289 (1991). Despite being at a higher risk for ischemic stroke, Black patients are substantially less likely to receive carotid endarterectomy. See, e.g., Eugene Z. Oddone et al., Race, Presenting Signs and Symptoms, Use of Carotid Artery Imaging, and Appropriateness of Carotid Endarterectomy, 30 STROKE 1350 (1999).
75. Id. at 30.
76. Id. at 29.
77. Id. at 31.
78. John Z. Ayanian et al., The Effect of Patients’ Preferences on Racial Differences in Access to Renal Transplantation, 341 NEW ENG. J. MED. 1661 (1999). The study, funded by the Robert Wood Johnson Foundation, was conducted with the assistance of four regional End-Stage Renal Disease Networks and the United Network for Organ Sharing. The authors surveyed 1,392 patients with end-stage renal disease and reviewed the medical records of 1,169 of them in Alabama, southern California, Michigan, Maryland, Virginia,
to the small difference in preferences (76.3% of Black women wanted a transplant vs. 79.3% of White women, and 80.7% of Black men vs. 85.5% of White men), Black patients were much less likely than White patients to have been referred to a transplantation center for evaluation (50.4% for Black women vs. 70.5% for White women, and 53.9% for Black men vs. 76.2% for White men), or to have been placed on a waiting list.

This Harvard study also found that Blacks patients were less likely to report that their primary nephrologist provided all the medical information they desired. This finding is consistent with other studies that report that the Black-White preference differential is related to patient knowledge about a surgical procedure. For instance, Whittle and his colleagues found that Black-White preference differences for coronary artery bypass surgery disappeared when the procedure was explained to Black patients. Furthermore, the study found that Blacks were substantially more likely to give a favorable response to the use of the procedure when the interviewer was Black.

African Americans do share a common legacy with regard to medicine. It is a cumulative experience of several hundred years of pseudoscientific racism and pervasive discrimination in medicine, unethical and often brutal experimentation, and abuse of Black people by both private institutions and government programs in health. Considerations of this sort suggest that, even assuming that some Black patients prefer not to undergo invasive medical procedures, it is a rational decision influenced by a past and historical memory of abuse and an attitude of distrust. If this is the case, there is a logical fallacy in using patient preferences as a variable in explaining disparate medical treatment. Such patient preferences do not explain racial disparities; rather, they demonstrate the consequences of racism. The refusal to undergo treatment is often associated with the fear of abuse and exploitation, and, on a more intimate level,
negative experiences with care providers can diminish preferences for robust treatment. Thus, different patient preferences, if they exist, are often a product of racial disparities in medical treatment. They do not explain them.

B. Overuse by Whites

The second claim is that racial disparities might reflect overuse of medical services by Whites, while Blacks receive the medically indicated and appropriate amount.

Health care is a scare resource. If some groups are receiving more of the resource than required by their medical condition, less is available for other groups, especially in the current environment of cost containment, capitated budgets, and rationing. Assuming that Whites are overusing medical services, a two-tier system of health care exists, in which those in the lower tier receive fewer services, irrespective of insurance status or condition upon presentation. Such a system perpetuates existing inequalities.

In any event, the history of Blacks and medicine makes clear that Black lives have not been as highly valued as White lives. That legacy is carried forward in the current views of Black patients. About 20% of Blacks believe that they have been unfairly treated when seeking care specifically.

84. Id.
85. See Arnold M. Epstein et al., Racial Disparities in Access to Renal Transplantation: Clinically Appropriate or Due to Underuse and Overuse, 343 NEW ENG. J. MED. 1537 (2000). The authors argue that despite abundant evidence of racial disparities in the use of surgical procedures, it is unclear whether these disparities reflect overuse or underuse of care. Id. at 1542. Their findings show that among patients considered inappropriate candidates for renal transplants, White patients were more likely to have been referred for evaluation and placed on a waiting list. Id. at 1541–42. Significantly, however, they also found a pattern of underuse of transplantation among Black patients. Id. at 1542.
87. See Reinhart Priester, A Values Framework for Health System Reform, 11 HEALTH AFF. 84 (1992). As a matter of justice, the right to equity in health care has a special claim: health care is essential to an individual's ability to participate fully in life's opportunities. Health is one of the more important aspects of personhood; a person's self-identification, dignity and status in society are often connected with that person's vitality and ability to function. Inequities in health care, then, indirectly affect social status, acceptance and the ability to attain a livelihood or enjoy social relations. See Lawrence O. Gostin, Foreword, Health Care Reform in the United States—The Presidential Task Force, 19 AM. J. L. & MED. 12 (1993). Strikingly different standards of health care for different racial groups is unjust for individuals who lose indispensable life opportunities and harmful for society generally, which loses much productive activity and risks greater disaffection among major segments of the population. Id.
because of their race. Twenty-seven percent of Blacks believe a friend has been unfairly treated. A larger number, 65%, are concerned that in the future, they or a family member will be treated unfairly when seeking medical care because of their race. Thus, it is unlikely that Black patients are receiving the appropriate amount of care.

C. Unconscious Racism

The third claim is that medical treatment disparities are the product of unconscious bias. Many studies that attempt to explain racial bias in medical treatment decisions do so in these terms.

While this analysis is fine and highly congenial to explaining a specific treatment decision by a specific physician, it does not answer a number of questions. First, is the pattern of racial disparities in medical treatment the result of an aggregation of specific, particular moments of unconscious racism over the thousands of treatment decisions that occur every day? Second, is unconscious racism in medicine the product of social indoctrination only, or do the history, practices, and attitudes of medicine in some way contribute to the problem?

Medicine is often portrayed as a mirror of society, reflecting prevailing societal attitudes. As Oliver Wendell Holmes states: "[M]edicine, professedly founded on observation, is as sensitive to outside influence, political, religious, philosophical, imaginative, as is the barometer to the atmospheric density."

If this is the case, individual physicians are logically the responsible parties for their unconscious acts of bias. The solution, then, is some form of cultural or sensitivity training, as is often proposed. This explanation,
This Article suggests that ideas about Black patients are transmitted to physicians by the institution of race-based research. Ignoring the role of medical institutions in originating and recreating taken-for-granted knowledge about Black patients renders invisible the relationship between medicine and politics. Medical institutions operate to fulfill the requirements of society. Historically, they have stood ready to supply the “scientific” justifications necessary for social and political needs.

In the following sections, I present a theory of how race-based research creates, legitimates, and sustains negative profiles of Black patients and reinforces taken-for-granted knowledge. This practice, in turn, leads to inferior medical treatment. First, I begin with a brief discussion of New Institutionalism.

III. NEW INSTITUTIONALISM

In a June 2000 Yale Law Review article, Ian F Haney López presents an elaborate theory of institutional racism, based on the principles of New Institutionalism. This Article expands the Haney López analysis to include several significant insights from New Institutionalism that are essential in understanding the medical institutions discussed in Parts IV and V of this Article. Specifically, I expand the analysis to include a more comprehensive description of how institutions are founded, how they are sustained and how they develop and retain a perspective that ignores the past. An institutional analysis is helpful for two principle reasons. First, it identifies and clarifies the symbiotic relationship between actors who discriminate, on the one hand, and specific organizational practices, norms, and processes that perpetuate discrimination, on the other. Moreover, an


95. See Deborah Lupton, Medicine as Culture: Illness, Disease and the Body in Western Societies 19 (1994) ("[T]he institution of medicine has an important part to play in social control, in shaping the regulation of human action, the deportment of human bodies and the construction of subjectivity.").

96. See infra Part IV.B.

97. Haney López, supra note 14. Haney López notes that his focus on individual behavior within institutions provides “a subtle but significant difference in emphasis relative to the theorizing of much, but not all, New Institutional scholarship.” Id. at 1723 n.21. This article follows much, but not all, of Haney López’s synthesis of New Institutionalism, and therefore reflects a similar difference in emphasis.
institutional analysis addresses the issue of effect and practice, rather than intent. Institutional actors may harbor no racial prejudice but nevertheless may help perpetuate organizational patterns and processes that become self-sustaining and discriminatory.

A. A Technical Definition of Institution

"Institution" has a distinct conceptual meaning; it denotes practices, patterns of behavior, and routines, rather than organizations. Through the operation of various mental processes, frequently repeated patterns of activity take on a rule-like status such that they are unconsciously followed. Put simply, institutional analysis posits that we often act without a consciously formulated purpose simply because "it is the way that it is done." Jepperson defines institutions as "those social patterns that, when chronically reproduced, owe their survival to relatively self-activating processes." DiMaggio and Powell make the additional claim that "organizational forms, structural components, and rules, not specific organizations, are institutionalized." Institutions within an organization serve two primary functions. First, they establish identities for members of the organization and activity "scripts" for such identities. Of equal importance, patterns of behavior, routines, and practices function to determine the bounds of what is organizationally appropriate.

98. Jepperson, supra note 13, at 143.
100. See id. New Institutionalism explicitly rejects rational choice models, which focus on intentional or purposeful actions by maximizing individuals. See Paul J. DiMaggio & Walter W. Powell, The New Institutionalism in Organizational Analysis 1, 7–10 (Paul J. DiMaggio & Walter W. Powell eds., 1991). Rational action models, prominent in economics, argue that individuals rationally pursue interests such as status, identity, and material gain. See, e.g., Richard H. McAdams, Cooperation and Conflict: The Economics of Group Status Production and Race Discrimination, 108 Harv. L. Rev. 1003 (1995) (arguing that racial discrimination results from one group seeking to produce esteem or status for itself by lowering the status of other groups). In rejecting rational choice models, New Institutionalism turns toward cognitive and cultural explanations of behavior that cannot be reduced to aggregations or direct consequences of an individual's attributes or motives. DiMaggio & Powell, supra, at 8. As a result, the theory is capable of explaining the large class of cases in which individuals do not see themselves as discriminating or taking directed action that harms other groups. Moreover, institutionalism focuses attention not on actions in isolation but on the organizational contexts in which interaction occurs, and on the received grammars and background rules that dictate individual behavior. Haney López, supra note 14, at 1784.
101. Jepperson, supra note 13, at 145
102. DiMaggio & Powell, supra note 100, at 14.
103. Jepperson, supra note 13, at 146. Jepperson argues that institutions embody "programmed actions or common responses to situations." Id. at 147 (citations omitted).
104. DiMaggio & Powell, supra note 100, at 11.
B. Founding Principle—An Analogy to Nature

An institution is typically developed to mediate competing powers and interests. Once established, it needs a stabilizing principle to justify its formal structure. Reference to the mandates of nature serves such a function. Mary Douglas explains:

[T]he incipient institution needs some stabilizing principle to stop its premature demise. That stabilizing principle is the naturalization of social classifications. There needs to be an analogy by which the formal structure of a crucial set of social relations is found in the physical world, or in the supernatural world, or in eternity, anywhere, so long as it is not seen as a socially contrived arrangement. When the analogy is applied back and forth from one set of social relations to another and back from these to nature, its recurring formal structure becomes easily recognized and endowed with self-validating truth.

As an example, the institution of the division of labor between the sexes is often justified by nature: the "natural" distinction of sex or physiological naturalism has historically specialized women for childbearing and rearing, and left other areas such as politics and commerce as avenues for men only. Nineteenth-century physicians frequently wrote about the corrosive effects of the women's rights movement:

'Woman's rights' now are understood to be, that she should be a man, and that her physical organism, which is constituted by Nature to bear and rear offspring, should be left in abeyance, and that her ministrations in the formation of character as mother should be abandoned for the sterner rights of voting and law making.

Currently, the pattern, or institution, of discrimination against gays and lesbians is often justified by reference to nature and what is considered natural and unnatural. Moreover, the history of race...
discrimination amounts to the search for "natural" differences that justify the subordination of people of color.

C. Institutions Rely on Unconsidered Knowledge

New Institutionalism makes both cognitive and cultural claims. The cognitive claim is that background understandings and rules serve as unseen antecedents to action. Harold Garfinkel argues that the existence of unconsidered background knowledge, rules, and the bracketing or elimination of doubt are necessary conditions for rational action:

In the conduct of his everyday affairs in order for the person to treat rationally the one-tenth of this situation that, like an iceberg, appears above the water, he must be able to treat the nine-tenths that lies below as an unquestioned and, perhaps more interestingly, as an unquestionable background of matters that are demonstrably relevant to his calculation, but which appear without being noticed.

The social actor applies certain "rationalities" to the unexamined background facts of social life. New Institutionalism views rationality in

10. Douglas argues that many oppositional categories are founded in nature; something as simple as the difference between the right and left hand has been used to justify social divisions and categories. Douglas, supra note 105, at 49. Although not explicitly basing his theory on an analogy to nature, Jacques Derrida argues that a structure of polarized categories is characteristic of Western thought:

Western thought ... has always been structured in terms of dichotomies or polarities: good vs. evil, being vs. nothingness, presence vs. absence, truth vs. error, identity vs. difference, mind vs. matter, man vs. matter, soul vs. body, life vs. death, nature vs. culture, speech vs. writing. These polar opposites do not, however, stand as independent and equal entities. The second term in each pair is considered the negative, corrupt, undesirable version of the first, a fall away from it .... In other words, the two terms are not simply opposed in their meanings, but are arranged in a hierarchical order which gives the first term priority.

Jacques Derrida, Dissemination viii (Barbara Johnson trans., 1981). Some critical race scholars have used these deconstructed bipolar associations to refute social belief about race and social worth. E.g., Daria Roithmayr, Deconstructing the Distinction Between Bias and Merit, 85 Cal. L. Rev. 1449 (1998).


12. Id.

13. Drawing on the work of Alfred Schultz, Garfinkel suggests that the "practical theorist" employs certain rationalities to order the social world. These behaviors include: (1) categorizing and comparing; (2) tolerable error, that is, varying degrees of attentiveness to the degree of fit between an observation and a theory; (3) search for means; (4) analysis of alternatives and consequences; (5) strategy; (6) concern for timing; (7) predictability; (8) rules of procedure; (9) choice; (10) grounds of choice; (11) compatibility of end-means
terms of the *processes* by which a social actor makes a decision.\textsuperscript{114} Using Garfinkel’s analogy, the social actor applies certain rationalities to the unexamined nine-tenths of the iceberg that lies beneath water in order to make a decision about what to do about the one-tenth of the iceberg (the new situation) above water.

New Institutionalism’s cultural claim is that the individual is constituted through social interaction.\textsuperscript{115} Unconsidered reliance and acceptance of unspoken rules and background knowledge—the “natural facts of life”—are not matters of mere convenience, but serve to establish standing as a member of the group.\textsuperscript{116} Further, in conforming to background rules, individuals not only establish membership in a given culture but also take on an identity.\textsuperscript{117}

D. The Reproduction of Institutions

Once institutionalized, routines and patterns are reproduced because individuals cannot conceive of alternatives, or because they view as unrealistic the alternatives that they can imagine.\textsuperscript{118} Structures and behaviors that are institutionalized are slow to change because institutions do not simply constrain options: they, in fact, provide the background knowledge and rules by which people discover reality and their preferences.\textsuperscript{119}

Moreover, the origin of the institution, typically the suppression of one set of competing interests over another, is forgotten. The resulting social arrangement is unquestioned. As Mary Douglas states: “The high triumph of institutional thinking is to make institutions completely invisible. When all the great thinkers of a period agree that the present day is like no other period, and that a great gulf divides us now from our past, we get a first glimpse of a shared classification.”\textsuperscript{120}

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\textsuperscript{115} See John W. Meyer et al., *Ontology and Rationalization in the Western Cultural Account*, in *Institutional Structure: Constituting State, Society, and the Individual* 12 (George M. Thomas et al. eds., 1987)(“[I]nstitutionalized cultural rules define the meaning and identity of the individual and the patterns of appropriate economic, political, and cultural activity engaged in by those individuals.”).

\textsuperscript{116} Garfinkel, supra note 111, at 275.

\textsuperscript{117} Id.

\textsuperscript{118} DiMaggio & Powell, supra note 100, at 14.

\textsuperscript{119} Id. at 10–11.

\textsuperscript{120} Douglas, supra note 105, at 98–99.
This institutional amnesia separates the present from the often inglorious past. For example, as detailed in Part IV below, current medical research continues to engage in the very same comparative studies of Blacks and Whites that, historically, were used to stamp Blacks as inferior. One reason for this practice is the invisibility of the institution of racialized research and the false belief that scientific progress has bracketed and erased the ill motives and dangerous consequences of the past.

Finally, as Haney López points out, not all institutionalized, self-activating routines and patterns of behavior constitute institutional racism. A necessary condition for institutional racism is that patterns and routines are undertaken in reliance on taken-for-granted background facts about race. A sufficient condition for institutional racism is that the actions have the effect of enforcing a racial status hierarchy. Such institutional practices impose substantial injuries on minorities, even if they do so in a quiet, unconsidered manner.

In sum, institutional racism is understood neither as purposeful action nor as the existence of widespread neutral practices that have a negative impact on people of color. Instead, institutional racism arises from self-activating patterns of behavior that are based on unconsidered background facts about race and serve to degrade a group's social and/or material standing.

Part IV applies the insights of New Institutionalism to show how the institution of race-based research arose from an ideology of White supremacy, became self-perpetuating, and creates dangerous beliefs and expectations about Black patients that influence clinical judgment.

IV. RACIALIZED RESEARCH

A. Background

Researchers conduct comparative medical and epidemiological studies to explain observed differences in health. This work uses race as a variable to explain, say, differences in the incidence of disease, variations in health outcomes, differences in survival rates from all types of diseases, disparities in responses to treatments, and differences in the etiology or pathways of disease. This Article defines racialized research as biomedical studies that use race as a variable.

Historically, racialized research has been neither neutral nor objective. In the United States, White physicians have used science to provide

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121. See infra Part IV.
123. Id. at 1810–11.
124. Id.
125. Id.
the data and theory necessary to legitimize the prevailing belief that Blacks were fit only to be slaves. The necessity for conducting comparative studies to prove the inferiority of Blacks was considered self-evident; few practitioners or researchers questioned whether their work was ethical. From the outset, the search for difference equaled the search for inferiority.

While the original meaning and intent of racialized research is ignored or forgotten, contemporary work continues the historical degradation of Blacks. Biomedical scientists, like all of us, have a set of beliefs about the natural world that inform the development of their ideas. Beliefs about race and its relationship to health and disease are influenced by the prevailing mythology of innate racial differences that has evolved within our society. But of equal importance, the process that creates racialized research hypotheses exploits and accepts prior ideas about racial differences developed within the biomedical community.

Institutional analysis suggests that in highly formalized settings, patterns or practices become programmed because "this is how things are done." Thus, in deciding what to observe, what questions to ask, and what hypotheses to form, the unquestioned knowledge that Blacks are biologically and culturally different serves as an unseen and unquestioned antecedent.

126. See Patricia A. King, Race, Justice, and Research, in Beyond Consent: Seeking Justice in Research 88, 92 (Jeffrey P. Kahn et al. eds., 1998).
127. See Bhopal, supra note 11, at 1751.
129. Jay S. Kaufman & Richard S. Cooper, In Search of the Hypothesis: Racial Differences and Disease, 110 Pub. Health Rep. 662 (1995). Historians and philosophers of science have pointed out that the cultural context of science comprises both scientific conventions and more broadly applicable social norms. See, e.g., Ellen Deason, Court-Appointed Expert Witness: Scientific Positivism Meets Bias and Deference, 77 Or. L. Rev. 59, 102 (1988). In the words of essayist Stephen Jay Gould in his examination of "scientific" attempts to measure intelligence: "Facts are not pure and unsullied bits of information; culture ... influences what we see and how we see it. Theories, moreover, are not inexorable inductions from facts. The most creative theories are often imaginative visions imposed upon facts; the source of imagination is also strongly cultural." Steven Jay Gould, The Mismeasure of Man 54 (rev. ed. 1996).
131. See Kaufman & Cooper, supra note 129, at 663 (asserting, that because of the environment in which biomedical scientists operate, "[i]t is unlikely that scientists decide to conduct comparative racial studies totally devoid of prejudice"). Newton G. Osborne & Marvin D. Feit, The Use of Race in Medical Research, 267 JAMA 275, 275 (1992).
Racialized research can be viewed as a subtle form of institutional racism. The pattern or practice of conducting racialized research relies on taken-for-granted and self-perpetuating background facts about Blacks (difference and inferiority) that serve to lower the health status of Blacks. Moreover, the use of Whiteness as the norm by which other racial groups are compared perpetuates White race-consciousness and privilege. Reliance on simplistic and seductive Black-to-White comparisons also reinforces our system of racial categorizations, and reifies the distinctions between Blacks and Whites that are at the core of racist beliefs.  

B. Race, Medicine and the Ideology of Oppression—Historical Overview

The institution of racialized research arose from the political and ideological purpose of proving the cultural and biological superiority of one race, White, over another, Black. Blackness comprised the binary opposite of Whiteness and was taken as a “natural” outward manifestation of inward mental, biological, and moral inferiority. Medicine played a pivotal role in profiling Blacks as an inferior people. The arrival of Blacks in Jamestown was a seminal event in stimulating concern and debate about differences between Blacks and Whites. If Blacks were anatomically and physiologically the same as Whites, then they were entitled to the same rights and privileges. Physicians in the United States made it their business to be involved in the great debate about slavery. “For these physicians, the fate of the nation hinged on one
key question which medical science alone could answer: are [B]lacks innately inferior to [W]hites and therefore fit only to be slaves?"137

Both reactionary and abolitionist physicians used medical science to support their contradictory agendas.138 The majority of doctors asserted that innate racial differences, as reflected in differences in health, required Blacks to be slaves and Whites to be masters.139 These differences made Blacks susceptible to disease, prone to violence and crime, lazy, and irrational.140

Blacks were initially considered a different species because they could work on rice fields in swampy lands, while many Whites became susceptible to malaria and fever.141 Many White physicians proclaimed that Blacks were "exempt" from yellow fever and malaria.142 The medical community favored the theory of an "innate" difference, despite evidence that Blacks were also dying from these diseases, especially those who had lived in this country for several generations. Furthermore, evidence showed that Whites living in swampy districts became less susceptible over time.143

By the first decade of the nineteenth-century, antebellum doctors had constructed their own "package" of essentially Black diseases.144 Tetanus, worms, diphtheria, whooping cough, pneumonia, tuberculosis, infant mortality, blindness, rheumatism, diseases of the nervous system, and scrofula, among others, were much more common in Blacks than in Whites.145 A review of Black diseases by Dr. E. M. Pendleton of Sparta, Georgia in 1849 demonstrates how physicians were convinced that innate difference explained disparities in disease. Concerning diseases of the brain and nervous system, Pendleton theorized that White brains were made of more delicate fiber and brought into much greater activity. He also attributed the higher incidence of miscarriages to the unnatural tendency of Black women to destroy their offspring.146

138. Id.
139. Id. at 260.
140. Id.
142. Physicians attributed differences in Blacks' susceptibility to their skin and surface glands, that is, they had a different capacity for perspiring than Whites. In an era when the technical limitations of science prevented the identification of viruses associated with malaria and yellow fever, there was no knowledge of the sickling trait in Blacks from West Africa, or of acquired immunity in general and therefore social beliefs filled the scientific void. Krieger, supra note 137, at 264.
143. Id.
144. KIPLE & KING, supra note 141, at 77–78.
145. Id.; Krieger, supra note 137, at 263.
146. Krieger, supra note 137, 263–64 (citing E.M. Pendleton, Statistics of Diseases of Hancock County, 5 S. MED. SURGICA L.J. 647, 649 (1849)). During this same period, medi-
In 1850, at the request of the Louisiana State legislature, a group of physicians led by Dr. Samuel A. Cartwright embarked on a study of Black health in the state.\textsuperscript{147} Inferring that oxygen deficiency was the primary biological explanation for what he described as Black lethargy, Cartwright concluded that slavery was the only proper antidote to Blacks’ natural torpor.\textsuperscript{148} Moreover, Cartwright called for Southern medical schools to promote the study of the “peculiarities” of Black physiology.\textsuperscript{149}

Throughout the nineteenth century, the physician remained the chief source of information for racialized research.\textsuperscript{150} After the Civil War, several factors stimulated the continued study of Black and White differences. A faulty statistical analysis of the Ninth and Tenth Censuses of 1870 and 1880 pointed to an apparent decline in the percentage of Blacks relative to the total population.\textsuperscript{151} Moreover, statistical evidence from the United States Army, investigations of American insurance companies, and corroborating beliefs of physicians all pointed to an increase in Black mortality and a decline in Black health status.\textsuperscript{152} Spurred by this alarm, physicians began to study and publish reports on comparative mortality, health, and physiology.\textsuperscript{153}

cine naturalized slavery by inventing diagnostic categories such as drapetomania (the “irrational” and pathological desire of slaves to run away from their masters) and dysaethesia Aethiopica (known to overseers as “rascality,” whose symptoms included sleeping during the day and a tendency to break, waste and destroy everything they handled). Waqar I.U. Ahmad, Making Black People Sick: “Race”, Ideology and Health Research, in “RACE” AND HEALTH IN CONTEMPORARY BRITAIN 11, 15 (Waqar I.U.Ahmad ed., 1993).

147. Krieger, supra note 137, at 268–269. Nancy Krieger explains:

After exhaustively detailing every racial difference imaginable—ranging from hair texture and brain size to bone density and hue of internal organs—Cartwright announced that he had discovered the ultimate physiological basis of [B]lack inferiority: their inability to consume as much oxygen as [W]hites, a consequence of certain ‘peculiarities’ of the [B]lack nervous system.

Id.

148. Id. at 268.

149. Id. at 269. At the time, Black slaves were used as live specimens for clinical instruction in most southern medical schools and Black cadavers were used for dissection. Grave robbing for such purposes was common. See, e.g., Todd S. Savitt, Medicine and Slavery: The Diseases and Health Care of Blacks in Antebellum Virginia (1978).


151. Id. at 154.

152. Id.

153. As Haller notes, “[t]heir studies suggested that a fundamental change was taking place in the physiological and pathological makeup of the Negro since the days of slavery—that the post-war Negro was succumbing to disease in far greater numbers than the antebellum generation, and that the Negro seemed precariously close to extinction.” Id. at 155.
These comparative studies yielded a variety of explanations. After hundreds of such studies, medicine conveyed the message that emancipation had been too overwhelming for Blacks; the Black constitution and habits of behavior were so "notoriously incompetent" that they could not exist as an equal in a free society.

Only a handful of physicians advanced the view that the declining Black health status was not primarily a consequence of innate differences, but rather reflected the negative consequences of poverty, dislocation, and subordination. Powerful forces, however, silenced those who argued that racial disparities in health were an effect of racism, rather than caused by race.

In the early twentieth century, racialized research continued to proliferate. In 1948, Julian H. Lewis, the Director of Research at Providence Hospital in Chicago, proposed a research program that added disease as an additional attribute of race. He stated:

[I]t is to be expected that the various human groups, loosely called 'races' will exhibit differences in the kinds of diseases that affect them and in the ways they react to these diseases. Anthropological descriptions of a group of people are incomplete if they do not also include a statement as to behavior to disease, because this trait is as much a characteristic of them as is the color of the eyes or stature.

Twentieth-century medicine also focused on illnesses such as tuberculosis, syphilis and other diseases caused by microbes. "Once again prevailing attitudes that [B]lacks and [W]hites were different fed hopes that the diseases in question, tuberculosis for example, did not affect

154. Id. Haller points out that physicians had an unusual fascination with Black sexuality. Accepting, without challenge, the idea that Black men had larger abdominal and genital development, physicians concluded that by some mysterious and unnamed law of science, they must have inferior cranial and thoracic development. Because of the lower level of consciousness, as they saw it, the Black male had an innate tendency to give in to his sexual appetite. Id. at 160–61.

155. Id. at 156.

156. See Krieger, supra note 137, at 272. During this period, to secure a monopoly on the medical profession, graduates of medical schools attempted to drive popular competitors from the field and to halt the rapidly expanding populist health movement. They attempted to accomplish this by actively lobbying state legislatures to pass restrictive licensing regulations. Under these circumstances, physicians had more to lose than gain by challenging the scientific proof of Black inferiority trumpeted by politicians on both sides of the slavery issue. See Paul Starr, The Social Transformation of American Medicine 92 (1982) (explaining that the nineteenth century medical profession was competitive rather than corporate).

[B]lacks and [W]hites in the same way or were really two different diseases.\textsuperscript{5,58}

Four themes emerge from this brief overview. First, racialized research originated within the context and ideology of White supremacy. Second, researchers associated differences in Black health status and mortality with biological and cultural difference in the races, without scientific proof. Third, once the research began, it became self-perpetuating and the theory of innate differences assumed a rule-like status. Finally, in the presence of technical issues that science could not address, researchers resorted to prevailing social views to explain the causal link between perceived differences and health status.

C. Current Examples of Racialized Research

Contemporary racialized research continues the historical construction of Black patients as degenerate in relation to the White norm.\textsuperscript{59} Such research falsely treats as a default rule an inherent biologic difference between Blacks and Whites, and errs by attributing a complex physiological or clinical phenomenon to arbitrary aspects of physical appearance.\textsuperscript{60} These perceived differences are often outcome-determinative in medical treatment.

Current racialized research reports that Blacks respond more poorly to treatment, are more likely to die from expensive invasive medical procedures, and possess more virulent diseases and tumors.\textsuperscript{61} Further,

\begin{itemize}
\item 158. King, \textit{supra} note 126, at 93.
\item 159. In March 2001, Medline, the database of the National Library of Medicine, contained 13,592 citations under the search term “Negroid race,” of which 1301 appeared in 1999 or 2000. See Robert S. Schwartz, \textit{Racial Profiling in Medical Research}, 344 \textit{NEW ENG. J. MED.} 1392, 1392 (2001). These studies sought to show race-based differences, in, among other things, lipid metabolism, renal function, sexual maturation, drug metabolism and neurological diseases. \textit{Id}.
\item 160. \textit{Id}.
\item 161. See, e.g., Charles R. Bridges et al., \textit{The Effect of Race on Coronary Bypass Operative Mortality}, 36 \textit{J. AM. COLL. CARDIOLOGY} 1870, 1870 (2000) (“Black race is an independent predictor of operative mortality after CABG except for high-risk patients.”); Richard J. Gray et al., \textit{Adverse 5-Year Outcome After Coronary Artery Bypass Surgery in Blacks}, 156 \textit{ARCHIVES INTERNAL MED.} 769, 771 (1996) (“Our study shows a significantly higher mortality risk for [B]lack patients after CAB surgery”); Maria Mori Brooks et al., \textit{Predictors of Mortality and Mortality from Cardiac Cause in the Bypass Angioplasty Revascularization Investigation (BARI) Randomized Trial Registry}, 101 \textit{CIRCULATION} 2682, 2688 (2000) (“[B]lack race remained a significant predictor of death after adjusting for internal mammary artery use during the [revascularization] procedure.”); K. Rajender Reddy et al., \textit{Racial Differences in Responses to Therapy with Interferon in Chronic Hepatitis C}, 30 \textit{HEPATOLOGY} 787, 791 (1999) (“Racial differences in response to therapies have been identified in many diseases, including hypertension, diabetes, renal transplantation, and depression.”) (citations omitted); \textit{Respiratory Diseases Disproportionately Affecting Minorities}, 108 \textit{CHEST} 1380, 1380 (1995) (“[S]everal studies comparing minority with nonminority populations have noted differ-
racialized research suggests that Blacks are genetically disposed to a host of chronic diseases, including hypertension, obesity, prostate cancer, low-birth weight infants, left ventricular dysfunction, nicotine addiction, asthma, and Alzheimer's disease.162

Numerous papers published in the modern medical literature also reference race as an independent risk factor related to survival from prostate cancer, breast cancer, lung cancer, brain cancer, colon cancer, and esophageal cancer.163 Moreover, Blacks are viewed as having less favorable prognoses than White patients for other medical conditions such as Hodgkin's disease.164

From a cultural perspective, Blacks are similarly viewed as degenerate in relation to the White norm. Racialized research suggests that Blacks are less likely to comply with medical treatment, less likely to be knowledgeable about their disease, less likely to view the disease as diminishing their quality of life, and less likely to be involved in promoting their own health.165

ences in the incidence and natural history of tuberculosis (TB), sarcoidosis, obstructive lung diseases, and lung cancer.”). The National Institutes of Health has concluded that Blacks have a higher incidence of diabetes due to “unexplained genetic factors” and that excess cancer rates in Blacks are due to “greater vulnerability to histologically aggressive tumors (e.g., of the uterus and bladder).” James B. Wyngaarden, From the National Institutes of Health, 261 JAMA 200 (1989).


164. See Adel Zaki et al., Early and Late Survival in Hodgkin Disease Among Whites and Blacks Living in the United States, 72 Cancer 602, 603 (1993).

165. See Dennis E. Daniels et al., Race: An Explanation of Patient Compliance—Fact or Fiction, 86 J. Nat’l Med. Ass’n. 20 1994 (summarizing and refuting studies showing that race is an independent predictor of adherence to a hypertension reduction regime); M. A. Swanson et al., Noncompliance in Organ Transplant Recipients, 11 Pharmacotherapy 1735 (1991) (describing the causes of noncompliance with medication therapy among minorities); M. Morgan, The Significance of Ethnicity for Health Promotion: Patients’ Use of Antihypertensive Drugs in Inner London, 24 Int’l J. Epidemiology (suppl. 1): S79–S84 (1995) (summarizing the causes of a significantly higher stroke mortality rate among blacks in the United Kingdom).
Racialized research suffers from a host of methodological problems. It also perpetuates the mythology of race. As Schwartz argues, racialized research can potentially lead to "the danger of attributing a therapeutic failure to the patient's 'race' instead of looking for the real reason." Indeed, he suggests that attributing differences in a health variable to race "is not only imprecise but also of no proven value in treating an individual patient."

Without an articulated medical basis, however, biomedical researchers continue to conduct race-based studies to determine whether differences in health variables are the product of biological factors and cultural peculiarities. While current methodologies are, arguably, more sophisticated, the institution of searching for biological difference continues the historical practice. Fullilove explains:

All too often, when race is found to explain a significant portion of the variation in some health outcome, little is done to explain the meaning of the association. The result is that medical researchers act as if there were inherent—if undefined—differences between racial groups that, once

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166. For a comprehensive review of methodological flaws, see Richard S. Cooper & Vincent L. Freeman, Limitations in the Use of Race in the Study of Disease Causation, 91 J. NAT'L MED. ASS'N 379 (1999) (showing that race is confounded by social class, statistical adjustments for race effects may be misleading, and that the biological concept of race ignores the context dependency of genetic expression). See also, Thomas A. Laveist, Why We Should Continue to Study Race . . . But Do A Better Job: An Essay on Race, Racism and Health, 6 ETHNICITY & DISEASE 21 (1996) (demonstrating lack of conceptual clarity about race, flaws in the use of binary variables, and errors in sample selection); Kevin A. Schulman et al., The Roles of Race and Socioeconomic Factors in Health Services Research, 30 HEALTH SERV. RES. 180 (1995) (describing classification problems and aggregation issues, and arguing for greater refinement of socioeconomic variables).

167. The recent sequencing of the human genome lays to rest many of the notions of genetic difference. As one scientist states:

Fortunately, from the few studies of nuclear DNA sequences, it is clear that what is called 'race,' although culturally important, reflects just a few continuous traits determined by a tiny fraction of our genes. This tiny fraction gives no indication of variations at other parts of our genome. Thus, from the perspective of nuclear genes, it is often the case that two persons from the same part of the world who look superficially alike are less related to each other than they are to persons from other parts of the world who look different.


168. Schwartz, supra note 159, at 1392.

169. Id.

170. Laveist, supra note 166, at 22 (arguing that the current institution of race-based research has had the effect of slowing the development of "high quality" research on race and health).
Racial Profiling in Health Care

signaled, require no further explanation. In an odd way, there is little difference at times between our modern science and the discredited practice of using science and medicine to justify slavery in the antebellum South: Each assumes that racial differences are of unquestioned importance.171

After years of studying differences between Blacks and Whites, there is little evidence that such research has paid positive dividends to Blacks. As one prominent radiation and medical oncologist has noted: “Thus far, the designation of race as a major health care variable has not resulted in the improvement of care for anyone. Those who have benefited most from such practices have been health care researchers.”172

D. Racialized Research and Identity Politics

In nearly all racialized research published in the United States, the comparison group has been the majority (White) population. Far from being a neutral category, this approach consolidates Whites as the group with which all “others” should be compared; it also disregards research that demonstrates the value of studying variations in health among, say, Blacks, as opposed to always comparing them with White Americans.173 The norm in racialized research is and has always been an unspoken but taken-for-granted White norm. As Martha Minow has pointed out, “[t]he unstated point of comparison is not neutral, but particular, and not inevitable, but only seemingly so when left unstated.”174

Using White Americans as the norm assumes a genetic homogeneity among these diverse individuals and disregards intragroup differences; it also implicitly assumes that the racial groups with which Whites are compared are both homogeneous and genetically different. The White norm in medicine is rooted in history. As Iris Young has pointed out, “[N]ineteenth-century theorists of race explicitly assumed [W]hite European body types and facial features as the norm, the perfection of human form, in relation to which other body types were either degenerate or less developed.”175

172. ROACH, supra note 163, at 12–13.
175. IRIS MARION YOUNG, JUSTICE AND THE POLITICS OF DIFFERENCE 128 (1990). Young further points out that bringing these norms into the scientific discourse gave the assertions of superiority an additional authority as truths of nature. Id.
Illustrations in medical texts tend to portray the White male body as the standard human body, against which different bodies are compared.\textsuperscript{176} Moreover, by defining the “other” as different (usually as inferior), the dominant group implicitly defines itself against that definition (as normal and superior).\textsuperscript{177}

The normative use of the classification “White” in racialized research defers to and reinforces the social understandings of White identity and privilege. Kimberle Crenshaw demonstrates that the category “White” has historically served the political and ideological purpose of uniting heterogeneous groups of people who have different cultures, geographic origins, and economic statuses.\textsuperscript{178} The solidarity of such groups often results in “racial oppositionalism.”\textsuperscript{179}

Moreover, Crenshaw argues that White race-consciousness promotes and perpetuates racial hierarchy because the everyday practices of most institutions employ unstated White norms that are disguised by a stance of neutrality. Culture, in her view, accounts for the “otherness” that legitimates the poorer material conditions of Blacks.\textsuperscript{180} Biology, this Article argues, also accounts for some of the “otherness”, as researchers are wedded to the belief that Blacks are biologically different from the superior White norm and continue their efforts to prove it.

Ian F. Haney López argues that Whiteness has no biological significance and that the construction of race is the construction of relationships: “It is in the elaboration of these relationships—invariably relationships of domination and subordination, normativity and marginality, privilege and disadvantage—that [W]hite identity is given content.”\textsuperscript{181} He further argues that because White supremacy makes Whiteness the normative model, it remains transparent, “unexamined, shrouded in background shadows.”\textsuperscript{182}

In sum, the use of the White body as the point of comparison is neither neutral nor objective. Whiteness is relational, and its use as a scientific variable is inherently laden with meanings about difference, deviance and superiority. Whiteness as a variable obscures the heterogeneity among White populations and maintains White race-consciousness. It also allows

\begin{itemize}
\item \textsuperscript{176} See \textit{Lupton}, \textit{supra} note 95, at 132.
\item \textsuperscript{177} Ahmad, \textit{supra} note 146, at 18.
\item \textsuperscript{178} Crenshaw, \textit{supra} note 12, at 1374–82.
\item \textsuperscript{179} For instance, White race consciousness convinced poor Whites to support a slaveholding system that was against their economic interests; it also allowed the ruling plutocracy to undermine the accomplishments of the Populist movement by stirring up anti-Black sentiment among poor White farmers. In these and other instances, racial privilege compensated for class disadvantage. \textit{Id.} at 1374.
\item \textsuperscript{180} \textit{Id.} at 1377–82.
\item \textsuperscript{181} \textit{Ian F. Haney López, White by Law} 165 (1996) [hereinafter \textit{White by Law}]; \textit{See also} David Roediger, \textit{Towards the Abolition of Whiteness} 13 (1994) (arguing that Whiteness is utterly empty of content, existing only in the exclusion of others).
\item \textsuperscript{182} \textit{White by Law}, \textit{supra} note 181, at 158.
\end{itemize}
researchers to ignore the social, economic, and political advantages of being White in the United States, as well as the implications of such White privilege for health.

E. New Institutionalism and Racialized Research

This Article suggests that the bulk of racialized research has not improved the health status of Blacks. On the contrary, this work collectively supports the belief in distinct and intrinsically different Black and White races and implicitly points to the inherent superiority of the White race. Moreover, physicians rely on this unscientific background knowledge in making diagnostic and treatment decisions. This Section employs the tools of New Institutionalism to understand why such work continues, even though the individuals involved likely harbor no racist intent.

Numerous factors operate to maintain and justify the institution of racialized research. Searching for biological differences between Blacks and Whites to explain Black health status is a pattern of activity that is transmitted generationally: “This is how things are done.”

Lynn Zucker shows that higher rates of transmission of information and patterns of activity positively correlate to more organized and formal settings. Biomedical research is a highly organized and structured profession. It emphasizes a formalized body of knowledge, standardized training, shared criteria of validity and reliability, and the exclusion of competing paradigms. The transmission of knowledge in such organized settings is “more definitely patterned” and “more formal and less personal.” It exists as part of the external world and is treated as objective.

The link between the racist past and the current practice, as Douglas points out, is severed by an institutional amnesia. The scientific truth obtained from prior research, that Blacks are different, is accepted and takes on a rule-like status. Because the historic links between current comparative studies and scientific racism are unexplored, researchers do not recognize or intend to project pejorative feelings, perceptions, or attitudes. They are, however, institutionally channeled in that direction.

The a priori sense that this background knowledge is right is unquestioned because it is founded on an analogy to nature. In the minds of some, it seems “natural” that people who have different genes for phenotypic traits like skin color should also possess different genes for physiological function. Thus, to understand the inferior health status of

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183. Zucker, supra note 132, at 83.
184. See id.
185. Id. at 86.
186. DOUGLAS, supra note 105, at 98–99.
Blacks in this country, researchers are institutionally channeled to look for the genetic, biological, or cultural difference.\textsuperscript{188} Moreover, racialized research is maintained and perpetuated because many researchers cannot imagine plausible, alternative non-biological explanations for the inferior health status of Blacks. A host of deleterious conditions accompany Black status in the United States, including differential exposure to environmental toxins, community-level and individual stressors, and differential political power, both in terms of individual level of control and the allocation of societal resources.\textsuperscript{189} It is now well-established that physiological processes respond to psychological stress.\textsuperscript{190}

Today, however, the institution of racialized research largely ignores the different exposures facing people of color (e.g. residential segregation, discrimination, racism) and their physiological effects.\textsuperscript{191} These factors are presumed not to exist, or thought incapable of being measured with scientific precision. Of equal importance, "[W]hite physicians who focus on racism as opposed to cultural peculiarities or the genetic basis of disease are likely to be considered both as not 'real scientists' and as dangerous."\textsuperscript{192}

Starting with a belief in Black biological differences and some statistical knowledge, a Black-White difference can almost always be found.\textsuperscript{193} Research grants and evidence of "hard" clinical research ability and productivity have a vital impact on a researcher's prestige, recognition, and promotion.\textsuperscript{194} Racialized research is a major industry, and showing difference enhances the researcher's status.\textsuperscript{195} As Kaufman and Cooper point

\footnotesize
\begin{itemize}
\item \textsuperscript{190} See \textit{id.} (observing that the literature is heavily skewed in this area, reflecting the interests of researchers rather than the needs and priorities of communities of color; and
out: "Questionable techniques may be retained if they provide what is believed to be the 'right' answer, and in a society with deeply ingrained beliefs about racial differences, a scientific confirmation of these differences is the expected, and therefore the 'right', answer."

Finally, racialized research confers identity. Racial differences are one of the taken-for-granted background facts of medical and social life. Subscription to and replication of such facts constitutes researchers, first, as bona fide members of the biomedical community and, more fundamentally, as members of a privileged racial class. Conclusions of biological difference legitimate socially constructed racial categories. Nearly all researchers conducting these studies are White. Findings of racial difference perpetuate the fiction of race and confer membership in a privileged group.

V. INSTITUTIONAL RACISM AND RACIAL PROFILING

The consequence of flawed racialized research is often the racial profiling of Blacks as an unhealthy social burden who are less likely to do well and who, consequently, do not merit particularized attention. Whites, in contrast, are profiled as the "gold standard" of health. Osborne and Feit suggest that physicians rely on the findings of racialized research in deciding whether and how to treat Black patients:

Physicians have been known to diagnose, manage, and make recommendations based on perceptions they acquire from the literature . . . . Black women with an ectopic pregnancy or with appendicitis may be at risk of having a misdiagnosis of salpingitis because of a perception that "there is a high incidence of PID" in the Negro population.

This section of the Article attempts to particularize the claim that physicians rely on the findings of flawed racialized research by suggesting concrete ways that these racial profiles may unwittingly seep into clinical decision-making.

that such research constructs Black health issues based on a White agenda). See also, Paul Stubbs 'Ethnically Sensitive' or 'Anti-Racist'? Models for Health Research and Service Delivery, in 'RACE AND HEALTH IN CONTEMPORARY BRITAIN' 34, 46 (Waqar Ahmad ed., 1993) (suggesting that research concerns tell us more about the interests of the powerful than about Black people's and women's lives and health).


197. See, e.g., Leigh Fortson, Biomedical Research Warfare, BLACK ISSUES IN HIGHER EDUC., Mar. 18, 1999, at 25-29 (documenting the paucity of African Americans performing biomedical research and examining the consequences for the health status of the African American community).

198. Osbourne & Feit, supra note 131, at 278.
Medical students are taught and clinicians increasingly use evidence-based medicine in making treatment decisions. David L. Sackett defines evidence-based medicine as the "conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients." The "best evidence" is generally articles from the biomedical literature that study prevention, treatment, diagnosis, prognosis, causation, and the like.

Racialized research published in prestigious medical journals provides some of the "best evidence." The flawed conclusions of racialized research are ubiquitous, and provide the taken-for-granted background facts that Black patients are biologically different and have cultural peculiarities, poorer survival rates, and less successful outcomes from nearly every medical procedure. As a general matter, medical journal editors fail to ensure that when authors claim that race accounts for such differences in health outcomes, their data are not based on flawed methodologies, or the spurious results of selective sampling, imprecise definitions of race, or dubious hypotheses.

While no empirical work has been done that specifically examines physician decision-making in relation to the findings of racialized research, we do know that a positive correlation exists between the amount of medical journal coverage devoted to a given disease and physicians' assessment of the mortality rate associated with that disease. Specifically, researchers have found that greater medical journal coverage is significantly related to physicians' overestimate of the risk of dying from a disease. Thus, it seems likely that the number of articles devoted to Blacks' poorer prognosis from nearly every disease influences physicians' assessment of whether a particular Black patient will die from a particular disease, and provides the antecedent knowledge on which the actual treatment decision is based.

201. Osborne & Feit, supra note 131, at 278. NATURE GENETICS now requires authors to explain why they used particular ethnic groups or populations, and how such classifications were achieved. Census, Race and Science, 24 NATURE GENETICS 97, 98 (2000).
203. In a discussion on race and medicine, I recently asked a group of about 40 fourth year medical students whether they would recommend heart bypass surgery for a Black patient, given the fact that the best evidence points to a substantially lower survival rate for Blacks from this procedure. Although certainly not a scientific survey, several students
From a consequentialist perspective, a physician will be less inclined to recommend a procedure if the literature states that the odds are low that the treatment will be successful for a Black patient. The documented disparity in recommendations for, say, carotid endarterectomy is likely due to reliance on the “best evidence,” which indicates that the procedure is not effective for Blacks because of presumed biological differences.204

As a result, the utility of a given procedure is often decided a priori, without an individualized assessment of the patient’s condition.205 It is known that these sorts of people do not do very well. In sum, the “best evidence” often includes flawed conclusions about racial differences in health outcomes. This medical evidence reinforces the assumption that both the genetic constitution and the cultural background predispose a Black patient to various diseases and may modulate responses to certain therapies. Physicians may unwittingly rely on this knowledge in making diagnostic and treatment decisions.206

B. Judgment Heuristics and Racial Identifiers

A great deal of uncertainty is inherent in medicine. Interpreting clinical information and laboratory data is often difficult; in addition, there is uncertainty in establishing the relationship between clinical findings and disease, and in predicting the effects of various therapies.207

stated that they would use such evidence as a factor based on a belief in the validity of the survival data; others stated that because their education is heavily evidence-based, they are expected to rely on such information.

204. Based on a few studies involving a small number of Black patients, the conventional wisdom is that Black patients have lesions of the intracranial carotid arteries, whereas White patients have such lesions of the extracranial carotid arteries, which makes it easier to surgically remove. See, e.g., Robert J. Wityk et al., Race and Sex Differences in the Distribution of Cerebral Atherosclerosis, 27 STROKE 1974, 1977-78 (1996). This taken-for-granted knowledge arguably channels physicians in the direction of not providing the procedure for Black patients, even when it is clinically appropriate. See Eugene Oddone et al., Race, Presenting Signs and Symptoms, Use of Carotid Artery Imaging, and Appropriateness of Carotid Endarterectomy, 30 STROKE 1350 (1999) (finding that adjustment for appropriateness of carotid endarterectomy reduces but does not eliminate the importance of race).

205. Writing almost a century ago, W.E.B. DuBois observed: “We must not forget that most Americans answer queries regarding the Negro a priori, and that the least human courtesy can do is listen to the evidence.” W.E.B. DUBOIS, THE SOULS OF BLACK FOLK 75 (rev. ed. 1990).

206. This is not meant to suggest that most medical decisions rest firmly on empirical evidence. Indeed, the absence of professional consensus about appropriate diagnostic and therapeutic alternatives suggests that medicine does not possess a firm basis of scientific evidence. See Bloche, supra note 16, at 100. My claim here, however, is that Black difference and inferiority have taken on a rule-like status that is institutionally transmitted and originates, in large part, from the empirical literature.

207. Frederic M. Wolf et al., Differential Diagnosis and the Competing-Hypothesis Heuristic: A Practical Approach to Judgment Under Uncertainty and Bayesian Probability, in PROFESSIONAL
Renee Fox has pointed out that despite the enormous amount of information presented to medical students, a central task in becoming a physician is learning about the uncertainty rather than the certainty of knowledge. Moreover, one scholar states: "physicians, like most people, do not manage uncertainty very well and may be prone to making certain errors that may affect the quality of care."  

Physicians frequently reduce their cognitive loads by using a number of strategies. The medical literature describes these "simplifying cognitive procedures, or rules of thumb, [as] judgment heuristics." Studies of judgment heuristics show that they are often based on subjective models of the real world and employ stereotypical ideas about the probabilities of disease and the utility of treatment alternatives. Moreover, there is evidence that in forming judgment heuristics, physicians rely on information that is believed to be associated with a given condition, but that actually is not.

The meanings of race obtained from racialized research can be thought of as a judgment heuristic; these unscientific associations between race and disease allow physicians to form prior probabilities about the causes of symptoms, course of treatment, and prognosis of Black patients. In this regard, Steven Caldwell argues that race "serves as little more than a 'jog' to the memory of busy clinicians."  

There is inferential evidence that physicians use Black race as a judgment heuristic. During clinical rounds and medical presentations, patient race or ethnicity is one of the leadoff patient identifiers. Physicians use racial identifiers because they believe that this data can help them in making a diagnostic or prognostic decision. One prominent physician notes:

During my medical school training, I declined to use the patient's race in the introductory statement of a case presentation, believing that to include skin color in the history of the present illness section was only a reminder of a sad history we all share. This technique met with little acceptance, but I continued the practice during residency and fellowship.

209. Wolf, supra note 207, at 349.
211. Id. at 62–69.
training despite the frequent interruptions that occur to re-
quest skin color .... When asked a patient's race while
presenting the history of present illness, a reply of "that is a
physical finding" is usually sufficient to make the point.215

Caldwell and Popenoe surveyed the clerkship directors of 48 medical
schools and asked whether medical students were taught to use the terms
"Black" or "White" in the opening statements of case presentations.216
Roughly 90% of the clerkship directors answered "yes" or "variable." Based on
the responses, the authors concluded that describing race in the
opening line of the case presentation appears common, and that the prac-
tice is transmitted orally or is formally taught.217

Physicians and residents are much more likely to specify the race of
patients categorized as Black. Finucane and Carrese have found that Black
patients were far more likely than Whites to be racially identified at
morning report.218 This finding suggests that Whiteness does not operate
as a judgment heuristic in clinical decision-making. As the unstated norm,
Whiteness is transparent and unexamined, while Blackness is inherently
laden with meaning about difference, deviance, and superiority.
Forming judgment heuristics about Black health often leads to
needless suffering.219 Physicians may miss clinically relevant information or
assume the presence or absence of genetic or cultural factors that, in fact,
may or may not be present. For example, a physician might racially profile
a Black patient as unsuitable for beta-blockers for congestive heart failure

\[\text{215. Drew E. Lewis, Elimination of the Patient's Race from the Case Presentation, 6 J. Gen.
Internal Med. 382 (1990).}\]
\[\text{216. Caldwell & Popenoe, supra note 213, at 616.}\]
\[\text{217. Id. at 616.}\]
\[\text{218. Thomas Finucane & Joseph A. Carrese, Racial Bias in Presentation of Cases, 5 J. Gen.
Internal Med. 120, 121 (1990).}\]
\[\text{219. One could argue that reliance on questionable background facts about Black
patients violates the Code of Medical Ethics. Rule 9.121 of the Code of Medical Ethics
counsels physicians against allowing racial prejudice to influence clinical judgment. Rule
9.121 is, however, aspirational, not prescriptive. Rule 9.121 states in relevant part: "Dispari-
ties in medical care based on immutable characteristics such as race must be avoided ....
Physicians should examine their own practices to ensure that racial prejudice does not
Annotated Current Opinions (1992).}\]

Bedside bias is also troubling from a bioethics perspective. Racialized decision-
making subordinates the principle of individual autonomy to the principle of beneficence.
Racialized decision-making ignores the Black patient's preferences and individual auton-
omy and replaces them with what the physician thinks is best for the patient, using her
own race-influenced judgment about expected outcome and utility. As a result, the pa-
tient's dignity, health and humanity are compromised.
because racialized research reports that Blacks do not benefit from this therapy.\textsuperscript{220}

Bloche suggests that specific features of medicine such as time pressures, sleeplessness, and the subservience to authority that is inherent in medical training “imbue an inclination toward automatic, unreflective reactions to clinical situations” that enlarge the role of judgment heuristics and racial profiling.\textsuperscript{221}

In sum, race matters in medicine. The meanings associated with race are institutionalized; that is, they are transmitted through generations of physicians and maintained as an objective fact. These race-based associations allow physicians to “know” Black patients without making an individualized assessment of the patient’s complaint. Such racial profiling leads to errors in diagnosis, distorted judgments about the appropriate course of treatment, and, ultimately, to different and inferior medical treatment. It also potentially distorts the bond of trust between patients and physicians.\textsuperscript{222}

Reliance on unconsidered and false understanding of race is troubling because in medicine, “[t]he sort of respect, deference, accord, regard, attention and autonomy a person is assumed to warrant is affected by the biological standing of persons.”\textsuperscript{223}

C. Transactions Costs

Reliance on racial profiles allows physicians to take the simplest, lowest-transaction-cost route to diagnosis and treatment. Indeed, the institutionalization of medical knowledge about Black patients saves individual physicians the time and effort necessary to make an accurate, individualized assessment of the patient’s condition.\textsuperscript{224}

White physicians spend considerably less time with Black patients than with Whites, and are less likely to include Black patients in the deci-

\textsuperscript{220} Previous studies have suggested that Black patients with heart failure may derive less benefit from beta-blockers that prolong life and reduce the risk of hospitalization. A recent study by Yancy and others, however, shows the benefit of carvedilol (a beta-blocker) of a similar magnitude in both Black and White patients. Clyde W. Yancy et al., \textit{Race and the Response to Adrenergic Blockage with Carvedilol in Patients with Chronic Heart Failure}, 344 NEW ENGL. J. MED. 1358 (2001).

\textsuperscript{221} Bloche, \textit{supra} note 16, at 105.

\textsuperscript{222} Schwartz, \textit{supra} note 159, at 1392.

\textsuperscript{223} Leonard Harris, \textit{Autonomy Under Duress, in African American Perspectives on Biomedical Ethics} 133, 145 (Harley E. Flack & Edmund D. Pellegrino eds., 1992).

\textsuperscript{224} Minimization of transactions cost is, arguably, more likely to occur in a managed care setting. Because financial pressures are substantial in most managed care settings, primary care providers have limited time to spend with patients and may be expected to see as many as 40 patients a day. Sometimes the concerns of new patients are addressed in a ten minute visit. Rene Bowser & Lawrence O. Gostin, \textit{Managed Care and the Health of a Nation}, 72 S. CAL. L. REV. 1209, 1254 (1999).
sion-making process. A recent Johns Hopkins University study found that Black patients have significantly fewer participatory encounters with their physicians than do White patients. The investigators defined a participatory visit as one in which the physician asks the patient to help make a decision if there is a choice between treatments; the physician gives the patient control over treatment; or the physicians asks the patient to take some of the responsibility for treatment.

Moreover, a recent study shows that African Americans with a diagnosis of coronary disease recalled fewer physician recommendations of cardiac procedures. For instance, fewer Black males recalled physician recommendations of noninvasive tests, such as electrocardiograms and stress tests, than did White males, and Black females were less likely to recall physicians recommending stress tests. The authors suggest that racial disparities in the use of cardiac procedures may begin in the initial stages of the clinical encounter, when physicians make clinical decisions regarding diagnosis.

Of course, the cultural context of the physician/patient relationship is another important consideration. Patient race is associated with physicians' assessments of patient intelligence, feelings of affiliation toward the patient, and beliefs about the patient's likelihood of substance abuse and non-compliance. Moreover, physician education contributes to the

225. Lisa Cooper-Patrick et al., Race, Gender, and Partnership in the Patient-Physician Relationship, 282 JAMA 583, 586 (1999).
226. Id. at 585.
227. Bonnie K. Sanderson et al., Ethnic Disparities in Patient Recall of Physician Recommendations of Diagnostic and Treatment Procedures for Coronary Disease, 148 AM. J. EPIDEMIOLOGY 741 (1998). The source of the data was the response of inpatients admitted to five Alabama hospitals in three Alabama counties during 1989–1990. These counties had a large racial disparity in the use of treatment procedures for coronary disease. Interviewers asked the patients to recall physician recommendations of five procedures prior to their admission to the hospital: electrocardiogram, graded exercise test, coronary angioplasty, coronary angiography and coronary artery bypass grafting. Differences between groups remained after adjusting for demographic and social characteristics, self-reported cardiac risk factors, symptoms, and patients' knowledge of their disease. Id. at 741–49.
228. Id. at 744.
229. Id. at 747. Another study has found that fewer Blacks are referred to cardiologists when presenting with cardiac symptoms. S. L. Crawford et al., Do Blacks and Whites Differ in Their Use of Health Care for Symptoms of Coronary Heart Disease?, 84 AM. J. PUB. HEALTH 957, 960 (1994).
230. See, e.g., Jack A. Clark et al., Bringing Social Structure Back into Clinical Decision Making, 32 SOC. SCI. MED. 853, 853 (1991) (explaining that factors such as race, age, gender, social class, characteristics of the physicians' professional socialization and the organizational setting in which care is rendered determine the shape and outcome of the clinical encounter).
The cultural context of the physician/patient encounter is linked to the institution of racialized research. The use of race as a scientific variable medicalizes difference; that is, it legitimates and naturalizes racial categories. The reliance on cultural stereotypes in the physician/patient encounter can be thought of as institutional racism because it treats race as an unquestioned, natural part of the social order, and creates false and unconsidered good/bad dichotomies that lower the health status of Blacks.

D. The Vicious Cycle—Racialized Research, Racial Profiling and Treatment Disparities

Background patterns and understandings are hard to deinstitutionalize, particularly in organized settings. Moreover, as Haney Lopez has pointed out, "individuals often face incentive structures that make it less costly to abide by norms that they disagree with than to act to change them." Researchers who study Black health potentially face publication bias, loss of prestige, and lack of recognition as real scientists if they fail to abide by the norm of using race as a scientific variable. Physicians face incentives in terms of time and cognitive energy that deter them from viewing Black patients individually, reading the literature critically and interrogating their own racial views and prejudices.

Individuals and communities can, of course, alter institutional racism, but not in any precise, easy or predictable way. Medicine can begin the process by becoming more inclusive. As early as the mid-1850s, Dr. John S. Rock (a Black physician) challenged notions of Black inferiority, and explained that the problem with racist science was not what it looked at, but what it was able to see. In a May 2000 study, researchers at Duke University suggested that they had found evidence that the attitudes that affect the behavior of doctors in making treatment decisions based on race can be seen in the earliest stages of a student's medical school experience. Racial and sexual biases surfaced when first- and second-year students were asked to assess the conditions of a Black woman and a White man who they believed were real patients. In fact, the two were actors using identical scripts describing symptoms of chest pain. Saif S. Rathore et al., The Effects of Patient Sex and Race on Medical Students' Ratings of Quality of Life, 108 AM. J. MED. 561,562 (2000). With the information provided, the medical students who had been taught the underlying physiologic relationship between coronary artery disease and angina should have been able to diagnose a condition of angina in both "patients." Instead, the White students, who made up 86% of the 164 participants in the study, were more likely to diagnosis angina in the White "patient" than in the Black one (72% vs. 46%). In contrast, the minority students made similar evaluations of the two patients. Id. at 563–64.

See Zucker, supra note 132, at 105.

Haney Lopez, supra note 10, at 1829.

Id.
what it ignored. That is, as long as physicians refused to consider how slavery and poverty caused disease, they would only have biological rationales to explain racial differences in health.236

Evidence suggests that many Black physicians recognize the intersection of politics and medicine, and have resisted racial profiling.237 Nickens suggests that physicians of color are “more culturally sensitive to their populations and organize the delivery system in ways more congruent with the needs of a minority population.”238 Moreover, minority consumers actively seek and choose physicians of their own race and ethnicity.239 As one Black physician explains: “There’s a certain relief in their eyes that you can see. I don’t know how to translate how that feels—to see another person of color.”240

The selection of medical students should reflect the type of physicians society needs in the future. In 1997–98, Blacks comprised 8% of first year medical students.241 Projections show that to reach racial and ethnic parity with a managed care-based requirement of 218 physicians per 100,000 population, the number of Black and Latino residents would have to roughly double; the number of Native American physicians would have to triple.242

An intensive effort by the Association of American Medical Colleges helped to produce a 36% increase in minority enrollment—to 12%—between 1990 and 1995.243 But then the assault on affirmative action

236. See Kreiger, supra note 137, at 270–71, 276 (asserting that “if we are to defeat scientific racism, we must, in the tradition of Rock and so many others, participate in the political struggle to end racism itself”).
237. Black physicians are more likely to involve Black patients in treatment decisions and to allow more open communication. Cooper-Patrick, supra note 225, at 588. Since many people of color suffer from the same type of medical profiling, logic suggests that physicians from other ethnic/racial groups are more likely to display the same behavior in race concordant relationships.
239. See, e.g., Somnath Saha et al., Do Patients Choose Physicians of Their Own Race?, 19 Health Aff. 76 (2000) (finding that racial concordance exists after controlling for geography and accessibility).
243. In 1990, when more than 12% of the nation's population was Black, Blacks accounted for only 7.6% of first-year medical students and 5.9% of medical school graduates. Many of these students attended the predominately Black medical schools, Howard and Meharry. See Louis W. Sullivan, The Need for Affirmative Action in Medicine, 262 JAMA 343, 343 (1991). In response, the Association of American Medical Colleges initiated the "Project 3000 by 2000" campaign in 1990, which resulted in modest increases in the total number of underrepresented minority students in U.S. Medical Schools.
began. First, California voters passed Proposition 209, an initiative flatly barring so-called racial or ethnic preferences (even to pursue the goal of diversity) as a factor in admission to the University of California system.\textsuperscript{244} In the Fifth Circuit, the decision in \textit{Hopwood v. Texas}\textsuperscript{245} had the same effect for university admissions in Texas, Louisiana and Mississippi. These attacks go much further than the landmark Bakke case, brought by an unsuccessful applicant to the University of California, Davis, School of Medicine, which stated that race in certain circumstances could be a factor in admissions decisions.\textsuperscript{246}

Particularly disturbing is the fact that two-thirds of minority students attending medical schools are enrolled in public institutions.\textsuperscript{247} Yet, nearly all of the decline in minority student enrollment has occurred in public medical schools. Public medical schools in California, Louisiana, Mississippi and Texas have been disproportionately affected by this trend; collectively, medical schools in these states accounted for 44% of the decrease in the enrollment of people of color in 1996.\textsuperscript{248} If these trends continue, and there are strong reasons to believe that they will, enrollment levels will likely return to the levels of the 1970s or worse.

This Article suggests that physicians and biomedical researchers of color are less likely to be affected by the racialized thinking. Increasing the number of such physicians and researchers is a first, albeit small, step in ending racial profiling.

Because of the complexity of the problem, a single solution is elusive and, therefore, the issue must be attacked from multiple fronts. Education is essential and should emphasize the fallacy of using race as a scientific concept and the inherent dangers in practicing racial profiling. Also, because the disparate treatment of Blacks is a civil rights issue, the potential for relief under the civil rights statutes must be pursued.

\begin{itemize}
\item \textsuperscript{244} See John Bunzel, \textit{Post-Proposition 209; The Question Remains: What Role for Race?}, L.A. TIMES, Dec. 8, 1996, at M2.
\item \textsuperscript{245} 78 E3d 932 (5th Cir. 1996), cert. denied, 518 U.S. 1033 (1996) (holding that preferences based on race and gender are unconstitutional).
\item \textsuperscript{246} Regents of Univ. of Cal. v. Bakke, 438 U.S. 265 (1978) (Powell, J. concurrence). Justice Powell argued: "[t]he attainment of a diverse student body] clearly is a constitutionally permissible goal for an institution of higher education." \textit{Id.} at 312. Other justifications, such as remediying societal discrimination and increasing the number of physicians who practice in communities currently underserved, were not found to be a sufficient justification for racial classifications. \textit{Id.} at 309–12.
\item \textsuperscript{247} David M. Carlisle et al., \textit{The Entry of Underrepresented Minority Students Into US Medical Schools: An Evaluation of Recent Trends}, 88 AM. J. PUB. HEALTH 1314 (1998) (excluding students enrolled at the predominately Black medical schools, Howard, Meharry and Morehouse).
\item \textsuperscript{248} \textit{Id.} at 1315–16.
\end{itemize}
VI. CIVIL RIGHTS AND RACIAL PROFILING IN HEALTH CARE

Congress enacted Title VI of the Civil Rights Act of 1964 to prohibit the expenditure of federal funds on programs and activities that discriminate on the basis of race, color or national origin. Because federal financial assistance includes Medicare and Medicaid funds, and nearly every hospital and nursing home in the United States receives such funds, Title VI applies to the majority of health care institutions. Further, Title VI defines “program or activity” broadly; if any part of an agency or entity receives federal funding, Title VI generally prohibits discrimination throughout the entire entity or institution.

In 1999, the United States Commission on Civil Rights criticized Title VI enforcement efforts in the area of health care; the Commission’s report pointed out that the nondiscrimination provisions have not been fully enforced and implemented by the Office of Civil Rights (OCR), the branch of the Department of Health and Human Services charged with enforcement. According to the report, tangible civil rights violations are selectively enforced. Tangible civil rights violations include easily identifiable harms like maintaining segregated hospital and nursing home wards, requiring only racial minorities to pay a deposit for emergency room care, or refusing to admit a patient whose physician does not have admitting privileges at that hospital.

Considerations of this sort suggest that the more complex and intangible violations created by racial profiling present formidable challenges. The poor enforcement history of Title VI naturally gives rise to pessimism regarding the prospects of attaining racial equality in health through this legislation. The political leadership of President Clinton in passing the

249. 42 U.S.C. § 2000d (1994) (“No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”).
251. Watson, supra note 250, at 945.
253. Id. at 202.
254. Id.
255. Title VI, unlike other sections of the 1964 Civil Rights Act, relies primarily on administrative rather than judicial enforcement. Thus, its effectiveness is related directly to the political will of the administration in power. See Sidney Dean Watson, Minority Access and Health Reform: A Civil Right to Health Care, 22 J. L. Med. & Ethics 127, 130 (1994). As Watson argues, the OCR effectively abdicated its Title VI enforcement responsibilities in
Minority Health and Health Disparities Act of 2000, and in endorsing other on-going programs to decrease health disparities, however, potentially signals a willingness to change the status quo. Assuming that the current administration continues the policies of its predecessor in this area, this Article suggests that there exists within Title VI potentially promising and unexplored ways to address discrimination generally, including the intangible qualities of institutional racism.

If we are serious about invigorating Title VI enforcement, the cornerstone is the systematic collection of data from each health care provider that receives federal funds on racial disparities in the use of services and the choices of diagnostic and therapeutic alternatives. Indeed, the Commission on Civil Rights recommends this approach:

OCR and other HHS agencies should use existing research outlining disparities in health status and access to health care and incorporate this information in the development of civil rights policies and civil rights enforcement programs. This would include information on . . . the type of treatment offered based on race, ethnicity, and gender. The addition of these factors to data collection instruments could detect, at an earlier phase, potential discriminatory problems at a facility, and secure compliance to remedy such problems before awarding funds.

health care during the Reagan and Bush administrations, which placed a low priority on civil rights. Id.

256. On November 22, 2000, President Bill Clinton signed into law the Minority Health and Health Disparities Research and Education Act of 2000, Pub. L. No. 106-525, 114 Stat. 2495. The Act provides $150 million to establish a center at the National Institutes of Health to study health disparities among the nation’s minority populations. Id. at §§ 101, 201(b). The underlying goal is to eliminate racial disparities that result from the lack of access to care, money and prevention. Notably, the Act does not refer to racial bias in medical treatment as a causative factor of these disparities. Id. at § 2(1) (“Despite notable progress in the overall health of the Nation, there are continuing disparities in the burden of illness and death experienced by African Americans . . . compared to the United States population as a whole.”).

The Act is part of a more ambitious effort to eliminate racial disparities. In his radio address on February 21, 1998, President Bill Clinton announced the goal of eliminating racial disparities in six areas by 2010: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV infection/AIDS and immunizations. This initiative is focused on research to understand the reasons underlying racial/ethnic disparities, expanding and improving programs to purchase or deliver health services, programs to reduce poverty, programs to improve the safety and healthiness of children’s environments, and expanded prevention efforts. See David Satcher, The Initiative to Eliminate Racial and Ethnic Health Disparities is Moving Forward, 114 PUB. HEALTH REP. 283 (1999).

257. See SMITH, supra note 214, at 325; Geiger, supra note 22, at 816.

The conceptual basis for data collection by race and ethnicity is simple and appealing. All that is needed is for health care institutions and providers to compile and report the use of specific medical procedures by race and ethnicity. Existing and proposed health care "report cards" offer an existing system for data collection on access, quality, and outcomes. Most have undergone extensive development and review, and need only to be stratified by race.

Under this proposal, civil rights enforcement efforts could be directed at those institutions or facilities that have statistically significant racial disparities in the use of specific medical procedures or referrals to specialists. Optimally, OCR would withhold federal funds from such facilities.

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259. See Smith, supra note 214, at 326. The National Committee for Quality Assurance, which accredits health plans, uses the Health Plan Employer Data Information Set (HEDIS), to rate health plans based on preventive services, prenatal care, acute and chronic disease, and mental health and substance abuse. Under preventive medicine, for example, health plans must report rates of childhood immunizations, cholesterol screenings, mammography screening for women over the age of forty and pap smears for women aged fifteen to seventy. Regarding prenatal care, the criteria measure the amount of prenatal care in the first trimester. Under acute and chronic disease, the criteria include therapy after myocardial infarction. See Nat'l Comm. Quality Assurance, Health Plan and Employer Data Information Set (version 3.0 1998). The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has a set of quality measures based on HEDIS measures. Joint Comm. Accreditation Health Care Org. National Library of Healthcare Indicators: Health Plan and Network Edition (1997). Further, the Agency for Health Policy Research in the Department of Health and Human Services is engaged in a similar effort to develop a uniform set of indicators of health care quality. See Research Triangle Institute, Dep't. of Health and Human Services, Design of a Survey to Monitor Consumer's Access to Care, Use of Services Health Outcomes and Patient Satisfaction: Final Report (1995). Finally, the Foundation for Accountability, a coalition of purchasers and consumer organizations representing seventy million people, has released a set of quality and effectiveness measures. See Alain C. Enthoven & Carol B. Vorhaus, A Vision of Quality In Health Care Delivery, Health Aff., May/June 1997.

260. See Smith, supra note 214, at 326.

261. The central question then becomes: what magnitude of racial disparity is large enough to lead to a presumption of discrimination. Title VII litigation is instructive. The rule of thumb in Title VII litigation is that an 80 percent disparity is sufficient for a prima facie case. See Mark A. Rothstein et al., Employment Law § 3.18 (2d ed. 1999). This rule of thumb has been criticized. E.g., Elaine W. Shoben, Differential-Pass Fail Rates in Employment Testing: Statistical Proof Under Title VII, 91 Harv. L. Rev. 793, 805–06, 810–11 (1978) (arguing four-fifths rule fails to detect statistically significant disparities in large sample sizes, fails to consider magnitude of difference in pass rates, and may yield different results when comparing fail rates). In Watson v. Fort Worth Bank & Trust, 487 U.S. 977 (1988), the Supreme Court expressly refused to identify any single method by which the prima facie case for disparate impact can be established, and instead, favored a case-by-case approach. Establishing a precise magnitude is extremely difficult in this context as well, given the varying sizes of health care providers and the complex relationships between providers. Establishing pilot enforcement programs that examine data from a large cross-section of providers is one way to get a feel for the problem and develop suitable measures.
providers until the racial disparity is either explained or corrected. This would have the advantage of shifting the burden on health care providers to present evidence showing non-discriminatory reasons for the racial disparities in treatment and referrals to specialists.

Such an approach is not without precedent. It is instructive to look at the banking industry, which has historically treated similarly situated Black and White borrowers differently through an ongoing and pervasive practice of lending discrimination and redlining. Since 1990, the Home Mortgage Disclosure Act (HMDA) has required mortgage lenders to reveal demographic characteristics such as the race, gender and income of all mortgage applicants. In this way, evidence of racial disparity is used in the regulatory review process of bank merger and expansion requests.

Statistics are also increasingly being collected to combat racial profiling in criminal law enforcement. In a 1999 speech to the nation, President Clinton criticized race profiling and called for the collection of data on race-based stops. Legislators have also called for such data. Moreover, a federal appeals court recently held that motorists could potentially use statistics to show the requisite discriminatory effect of state police conduct to support their equal protection claims.

Besides the obvious advantage of identifying racial disparities in medical treatment and withholding government funds, data collection potentially compels institutions to think about race. As Sidney Watson has pointed out, "[i]t is only when providers know that something is 'wrong'..."
that they can be motivated to change the status quo to do what is 'right.'”

An internal dialogue should include these questions: Are Black and White patients offered the same options by physicians? Do assumptions about survival affect physicians' recommendations for certain procedures? Do physicians use judgment heuristics and racial profiling because of time pressure? Are physicians' treatment decisions influenced by racialized research that portrays Blacks as different, less likely to respond well to certain treatments, and less likely to adhere to costly treatment regimes?

Such data collection will also improve overall health care quality. Health care quality requires that resources are allocated according to medical need, risk, and benefit, not by alternative standards. Quality improvement experts have emphasized the importance of redesigning systems of care instead of simply identifying individual physicians who provide inadequate care. One way to do this is to implement information systems that provide medical groups and other facilities with timely feedback about treatment decisions, referral rates, and patient satisfaction according to race and ethnic background. Thus, a dialogue on addressing racial disparities and racial bias must be recognized as a serious quality issue.

Another advantage of a facility-level enforcement program is that it obviates the need for an individual plaintiff to identify the wrongdoer or the type of care that should have been provided. Prior to April 2001, there existed an issue as to whether Title VI entailed a private right of action. In Alexander v. Sandoval, however, the U.S. Supreme Court held that it did not create a private right of action concerning policies with disparate impact, absent a showing of discriminatory intent. Because of physician discretion, however, an individual claim of disparate medical treatment would have been difficult to prove even if a private right of action had been found. As Bloche explains, clinical variation presents an almost


270. Id.

271. See Arnold M. Epstein & John Z. Ayanian, Racial Disparities in Medical Care, 344 JAMA 1471, 1472 (2001). Major structural changes in health care, namely, the movement to managed care provides missed opportunities for identifying, monitoring and correcting racially discriminatory rationing by physicians and health care institutions. Managed care and risk-sharing arrangements and the growth of large integrated delivery networks provide economic incentives for health plans to develop health information systems that enable them to monitor internal processes and outcomes. Integrated and computerized clinical and information systems increasingly serve as an essential component of these health plans and delivery systems. See Cars, supra note 224, at 1258.

insurmountable obstacle in medical malpractice: "[L]ower intensity care provided to a minority patient can ... typically be defended as consistent with one or another widely accepted standard of care." 273

Further, publicly available, institution-specific racial information can conceivably provide an incentive for providers to voluntarily reduce racial and ethnic disparities in care, based on their own economic self-interest. 274

This approach assumes that purchasers of health care will take the existence of racial disparities into account in choosing health care providers. From a policy perspective, employers have been the major forces for change in the health care marketplace. 275

In particular, major corporations, as well as business and health coalitions, are increasingly banding together and using their market power to demand accountability and promote quality as well as cost. 276 From a legal perspective, states have assisted by passing legislation that either permits or encourages the voluntary creation of alliances among purchasers of health care. 277 Thus, major purchasers of health care conceivably have the bargaining power to require a reduction in racial disparities. Whether they have the desire to do so, however, is a much more complicated issue. 278

In making this case for collecting race-based treatment data, difficult operational issues need to be addressed. For instance, how do we classify races? The Office of Management and Budget provides a uniform classification scheme for data collected by all federal agencies, and those categories are also used by most state agencies, hospital discharge records,

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274. See Smith, supra note 214, at 230.
275. A recent study funded by the Agency for Health Care Policy and Research shows that employers in some parts of the country are taking advantage of the leverage they have with health plans to demand report cards on the services and outcomes provided by each plan. See Jack Meyer et al., Agency for Health Care Policy & Research, Theory and Reality of Value-Based Purchasing, Lessons From Pioneers 1 (1997).
276. Examples of such purchasing coalitions are the Pacific Business Group on Health; the Health Care Payers Coalition of New Jersey; the Buyers Health Care Action Group in Minnesota; the Employer Health Care Alliance Cooperative of Madison, Wisconsin; the Chicago Business Group on Health; the Business Health Care Alliance of Appleton, Wisconsin; and the Colorado Health Purchasing Alliance. See Bowser & Gostin, supra note 224, at 330.
278. One can argue that employers and other purchasers lack an incentive to push for race-based data and an elimination of disparities when shopping for a health plan. Notwithstanding the push for report cards and other quality measures, a recent study shows that the primary reason an employer chooses a particular health plan is cost. Washington Business Group on Health/Watson Wyatt Worldwide, Purchasing Information Employers Use to Select Health Plan 3 (1996) (on file with the Michigan Journal of Race & Law). Further, Black and other minority group employees likely lack the leverage to press employers to choose a health plan with low racial disparities.
and medical record keeping systems. One could argue that these classifications lump heterogeneous groups into one category and, furthermore, present the same problem as using race as a variable in racialized research, namely, they serve to validate socially constructed racial meanings and reinforce White race consciousness and privilege. On this account, then, are there any justifications for perpetuating the use of flawed racial categories?

One might draw a distinction between using the concept of race for research and for civil rights monitoring purposes. Race has served biomedicine badly. Medical research needs to rethink the concept of race as a variable; it might be disaggregated or eliminated altogether in order to account fully for intragroup differences in health outcomes, and to prevent science from ignore the truth that race has no scientific meaning. Some have called for broader measures such as ethnicity.

For purposes of civil rights monitoring, however, the study of racism would be impaired if we abandoned racial categories. Despite the imprecision of our definitions, measurable and substantial disparities exist among groups we label as races. Furthermore, advocates for social equality have long used race-specific statistics in calling for reform. In fact, abandoning racial categories for civil rights purposes would be welcomed by those who are disinclined to address the problems these statistics bring to light. Neoconservatives object to most race-based initiatives, including collecting racial/ethnic data in the United States.

An important legal issue that must be addressed is whether existing civil rights laws prohibit health care providers from collecting racial data. The Office of Minority Health has studied the issue and has concluded that no provision in either the Federal Civil Rights Act of 1964 or promulgated regulations prohibits health insurers or health plans from collecting racial data. Moreover, by law, The Department of Health and Human Services has the authority to obtain racial data from “from any entity that receives funding from DHHS to determine compliance with Title VI law or promulgated regulations on a case-by-case basis.” Three states, however, prohibit the collection of such data. The Office of Minority Health is now reviewing these laws and may eventually ask state

279. Smith, supra note 214, at 326.
280. See, e.g., Raj Bhopal & Liam Donaldson, supra note 173, at 1303.
281. J. Jacoby, If Race Shouldn’t Count, then Why Count It?, BOSTON GLOBE, November 18, 1997 at A25.
283. Id.
legislatures to consider revisions that would allow racial and ethnic data collection.\textsuperscript{285}

Even if plans are legally mandated to release treatment data by race, additional regulations will be required to provide assurances of confidentiality. For instance, health plans regard referrals to a specialist, one of the most significant indicators of racial bias, as proprietary and a closely guarded competitive secret.\textsuperscript{286}

Of course, it would be naïve to suggest that HHS can enforce this proposal alone. The history of hospital integration after the passage of Title VI and the enactment of Medicare legislation demonstrates the importance of local organizations. As Smith has pointed out, "a network of local civil rights organizations and health services workers, intimately familiar with the operations of local hospitals, did the 'real work.'"\textsuperscript{287} A critical challenge for local and national civil rights organizations, then, is to place the elimination of racial disparities in medical treatment at the top of their agendas and to demand accountability. Indeed, eliminating racial profiling in health care through Title VI enforcement must be pursued with the same vigor that has been directed towards eliminating barriers to other basic civil rights.

CONCLUSION

This Article suggests that medicine is not immune from the injustice of racial profiling. The lives of patients of color are devalued by race-based expectations that arise from the findings and conclusions of flawed racialized research. To the extent that medical judgment is informed by racial categorizations, it is bound to yield racially disparate results.

Three conclusions result from this study. First, medicine needs to re-think research. The publication of the first draft of the human genome project should force an end to research that is arbitrarily based on race. Second, medicine needs to rethink treatment. Education is essential and should emphasize both the fallacy of using race as a scientific concept and the inherent dangers in practicing race-based medicine. Third, society needs to rethink discrimination. By requiring providers who receive federal funds to report data on medical treatment by race and ethnicity, we

\textsuperscript{285} Personal communication with Violet Woo, Office of Minority Health, August 24, 2000. This is a noteworthy change in policy because in the past, HHS has been hesitant to require providers receiving federal funds to collect racial and ethnic data. In one court challenge, HHS successfully argued that the collection of statistical data on the ethnic distribution of health care services is discretionary, not mandatory, under Title VI. See Madison–Hughes v. Shalala, 80 F.3d 1121 (6th Cir. 1996) (challenging HHS' failure to collect racial data concerning the delivery of health services that would allow HHS to develop statistical data concerning minority access to federally funded health care).

\textsuperscript{286} SMITH, supra note 214, at 330–31.

\textsuperscript{287} Id. at 331.
can identify the extent of the problem, rectify treatment disparities, and, more fundamentally, begin a much-needed dialogue about the meaning of race in medicine.