

Race and Discretion in American Medicine

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Rarely has a piece of social science research received more attention than the 1999 study by Kevin Schulman and others reporting large differences in physicians' responses to identical heart disease symptoms presented by black and white actors portraying patients.¹ The 720 physician-subjects who participated in the study² referred lower proportions of African-American than white age and sex matched "patients" for cardiac catheterization, a costly, state-of-the-art diagnostic measure, even after the researchers controlled for physicians' subjective impressions of disease likelihood and severity. Critics quickly found errors in the authors' statistical methodology—errors that exaggerated these racial disparities.³ *The New England Journal of Medicine*, in which the article appeared, then took the extraordinary step of issuing a partial retraction.⁴

Yet publication of the Schulman study did more than any other single event to put the matter of racial disparities in health and medical care on the American public policy agenda—and to frame political discussion of the topic. Hundreds of prior publications reported powerful evidence of racial gaps in life expectancy, morbidity from various illnesses, access to health insurance and services, and the clinical management of disease.⁵ But the Schulman study's use of African-American and white actors with identical scripts presented a stark picture of pure racial bias, uncomplicated by the potentially mediating roles of educational background, economic status, or other social cues. The study received

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national media attention, and months later a congressional appropriations report termed its findings “alarming.”⁶ Report language spotlighting the Schulman study accompanied federal legislation funding an Institute of Medicine (IOM) inquiry into the scope, impact, and causes of racial bias in American medicine. A variety of other public and private sector initiatives targeted racial bias in American health care as a topic for research, discussion, and intervention.⁷

Racial disparities in health care provision that persist even when researchers control for income, education, and health insurance status are the primary focus of these initiatives. Efforts to understand the reasons for these disparities have focused on psychological, social, and cultural influences that affect providers’ clinical judgments and patients’ expressed preferences. In this Article, I explore institutional, economic, and legal factors that contribute to these disparities. This contribution, which I contend is larger than commentators on health care disparities typically acknowledge, occurs through interaction between organizational and legal arrangements and physicians’ exercise of clinical discretion. Because these arrangements are amenable to pragmatic intervention, they deserve close attention.

My focus in this Article is on racial disparities in medical care provision—that is, on differences in the services that clinically similar patients receive when they present to the health care system. Racial disparities in health status, which is not greatly influenced (on a population-wide basis) by medical care, are beyond my scope here. Disparities in medical care access—potential patients’ ability, financial and otherwise, to gain entry to the health care system in the first place, are also outside my focus. But I begin this Article by putting the problem of racial disparities in medical care provision within the larger context of disparities in health status and medical care access.

In Part I, I concede: (1) that medical care is almost certainly less important as a determinant of health than are social and environmental influences, and (2) that inequalities in Americans’ ability to gain entry to the health care system probably play a larger role in medical treatment disparities than do racial differences in the care provided to people who succeed in gaining entry. I then briefly examine the moral politics behind the appearance of racial disparity in health care provision on the national policy agenda, ahead of disparities in health status and medical care access. In Part II, I consider the links between clinical discretion and racial disparities in health care provision. I argue that pervasive uncertainty and disagreement, about both the efficacy of most medical interventions and the valuation of favorable and disappointing clinical outcomes, leave

ample room for discretionary judgments that produce racial disparities. Neither existing institutional and legal tools, nor prevailing ethical norms, impose tight constraints on this discretion. As a result, provider (and patient) presuppositions, attitudes, and fears that engender racial disparities have wide space in which to operate. In Part III, I refine this argument, pointing to a variety of extant organizational, financial, and legal arrangements that interact perniciously with psychological and social factors to potentiate racial disparities. Part IV considers the impact of the managed care revolution, contending that its cost containment strategies both contribute to racial differences in health care provision and create opportunities for reducing some of these disparities. Part V closes with some recommendations as to how health care institutions and the law might respond pragmatically to racial disparities even as they pursue other important policy goals.

I. INTRODUCTION: THE POLITICS OF DISPARITY IN HEALTH AND MEDICAL CARE

Notably missing from the national political agenda, though well documented in the research literature, are the larger problems of population-wide racial gaps in health status and access to medical care. Epidemiological research in the United States and abroad indicates that health care is only modestly important as a determinant of population-wide health. Variations in medical spending account for only a small portion of population-wide class and race-related differences in health status: life expectancy, infant mortality, and the incidence of many diseases correlate much more closely with income, education, environmental conditions, race, and ethnicity.⁸ Racial disparities in health care access arise in large part from socio-economic disadvantage and the consequently unequal affordability of medical coverage and services.⁹ Disparities in the health care Americans receive that persist after researchers factor out measures of socio-economic status are narrower.

Scholars in a diverse range of fields, from health services research to bioethics to developmental economics, have highlighted disparities in both health care affordability and health status, debated their causes, and proposed solutions. But there is no serious prospect of public action to ameliorate these disparities. Universal health insurance coverage would greatly reduce racial differences in health care access that result from disparities in ability to afford coverage, yet universal coverage has been off the American political agenda since the collapse of the Clinton administration's reform plan in 1994. The more intractable problem of racial disparities in health status has attracted some of the research

attention recently paid to social determinants of health,¹⁰ but our politics has not focused on these disparities as a problem in urgent need of a public policy response.

Why has racial bias in the clinical judgments physicians make on behalf of equivalently insured and socio-economically situated Americans generated a greater political response than has the racially unequal impact of allowing more than forty million Americans to go without medical coverage?¹¹ And, why have racial disparities in health status—a thing distinct from health care provision and not much influenced by it—received less political attention than has racial bias in physician judgment? The answers to both questions, I suspect, implicate our national tolerance for socio-economic inequality as a factor in disparities we deem unacceptable when they result purely and simply from racial bias. As a matter of law—and of politics—we tend to treat racial disparities in Americans' enjoyment of myriad goods, services, and benefits as less troublesome when they are mediated through socio-economic differences than when they arise from the overt bigotry of identifiable actors. Thus, racial disparities in access to health care (and in physicians' clinical recommendations) due to differences in insurance coverage¹² are more "acceptable" than up-front racial bias at the bedside, despite the known correlation between coverage status and race (and despite the causal role of prior racial subordination in present socio-economic disadvantage).

Racial disparities in health status are not readily tied to identified, racially biased actors. To the extent that these disparities arise from the disproportionate presence of minorities in lower socio-economic strata, they are subject to dismissal as epiphenomena of socio-economic inequality. Even the disparities that persist when indicia of socio-economic class are factored out cannot easily be linked to particular perpetrators. Explanations for these lingering health disparities have invoked stress from diminished social connection and repeated experiences of prejudice,¹³ as well as myriad losses of material opportunity that fail to register in assays of socio-economic status.¹⁴ The pervasive, often subtle discrimination these explanations entail cannot be traced to a small circle of identifiable perpetrators.

The politics of racial disparity in health matters has important practical implications. Framing the problem of racial disparity as one of bias in clinical judgments concerning patients who differ by race but are similarly situated in terms of insurance status and income draws attention away from race-related economic disadvantage and from illness-inducing stress arising from pervasive racial bias. To the extent that focusing on racial bias in therapeutic decisionmaking makes it politically more difficult

to direct public attention (and resources) toward the larger problem of race-related economic and social disadvantage (and its health consequences), there is tension between different approaches to the relationship between race and health. This tension is two-fold—between efforts to reduce bias in clinical judgment and to make coverage and care more affordable and between devotion of resources to medical care and to programs targeting the social and economic determinants of health status.

I do not mean by this to suggest that racial disparities in care provided to similarly insured and economically situated patients are other than deeply troubling and deserving of a robust public policy response. To the contrary, our national political attentiveness to matters of racial justice is intermittent and partial at best, and I believe we should seize opportunities when they arise.¹⁵ And it may even be that, rather than pulling attention away from other forms of race-related disadvantage, public focus on racial disparities in clinical decisionmaking could inspire national concern about other kinds of health disadvantage that disproportionately affect some racial groups.

In any event, racial disparity in medical decisionmaking has emerged on the public policy stage as both a health policy and a civil rights issue. More than many other civil rights problems, it has attracted bipartisan concern. We should endeavor to translate this visibility and concern into a pragmatic strategy for addressing racial bias in health care provision. In so doing, we should also keep our eye out for larger lessons, about how racially biased outcomes can result, even absent overt bigotry, from the decentralized exercise of discretion within the complex, fragmented institutional arrangements characteristic of much of contemporary American life.

To these ends, I will try, in the remainder of this essay, to identify ways by which the organization and legal governance of health care provision may foster racial disparities in clinical decisionmaking—and how legal change therefore might make a positive difference. I will also consider law's limits in this regard, as both an explanation for these disparities and a tool for ameliorating them. I am mindful that racial bias, in medical care as in other endeavors, is not solely, even primarily, a function of institutional or legal arrangements, and that not all health care disparities arise from providers' racial prejudices. Institutions and law nonetheless make a large difference, and modest change in the health care industry's legal environment might substantially reduce disparities in care provision.

II. CLINICAL DISCRETION AND RACIAL DISPARITY

My starting point for considering the role of institutions and the law is

the enormous discretion clinical caretakers routinely exercise and the similarly wide discretion of those who decide whether insurers will pay—utilization reviewers and, increasingly, treating physicians who act as gatekeepers. Most medical decisions do not rest firmly on empirical evidence. There are typically multiple diagnostic and therapeutic options, and wide variations in the incidence of many common medical and surgical procedures have been documented within small geographic areas and between individual practitioners.¹⁶ Absence of professional consensus about appropriate diagnostic and therapeutic measures often reflects the lack of undergirding scientific evidence. The paucity of scientific support for most medical decisions both contributes to clinical practice variations and makes it impossible in many cases to reach evidence-based conclusions as to which practice variations constitute over and underuse. Lack of agreement on how to value favorable (and unfavorable) clinical outcomes even when possible outcomes are empirically predictable amplifies medical practice variations.¹⁷ These variations create room for clinical discretion constrained more by different local and institutional traditions than by science-based medical practice parameters.

A. Legal and Administrative Constraints on Clinical Discretion

Neither private health insurance contracts nor the statutes governing publicly financed coverage (principally Medicare and Medicaid) contain language that meaningfully limits this discretion. Contractual and statutory provisions typically mandate coverage for all “medically necessary” care, subject only to categorical exclusions such as “investigational” therapy and care received “out-of-network” or not in accordance with required referral procedures. What constitutes “medical necessity” in particular cases is up to individual caretakers and utilization reviewers. The problem of general standards and the broad discretion they confer is, of course, familiar to lawyers. Courts and regulatory agencies manage the indeterminacy and inconsistency that come with this discretion in three principal ways. The classic method is the issuance of successive, published, more or less reasoned decisions in particular cases. This enables parties (and legal decisionmakers) in subsequent disputes to narrow the scope of discretion and limit the resulting indeterminacy and risk of inconsistency through efforts to reason by analogy from prior decisions. An alternative approach, more commonly followed by regulatory agencies, is the issuance of detailed decision rules all at once, in a comprehensive attempt to interpret general (typically statutory) standards. A third approach, taken tacitly by legal decisionmakers, is to cloak the exercise of discretion instead of trying to constrain it.¹⁸ Reliance on juries (which deliberate in secret and neither

give reasons nor set precedents) and on grievance and arbitration procedures that decide cases confidentially without creating precedent is illustrative. This approach does nothing about the problem of indeterminacy but keeps inconsistencies decorously veiled.

The first and second approaches are simply not feasible in the health care sphere. Nothing resembling the formal process of successive published opinions occurs when physicians make the scores of clinical judgments they render every day.¹⁹ To try to replicate such formality at the bedside would freeze the fluid process of diagnosis and therapy. To be sure, new information technology is making it increasingly possible to record major clinical decisions and their outcomes anonymously yet accessibly. But tracking down and comparing case histories in order to assess the relevance of prior outcomes for a present clinical situation will remain a complex, costly endeavor, subject to the infinite variability of clinical scenarios and to our ignorance about which comparable patient features are relevant to the clinical question at hand. Such comparisons, moreover, typically constitute cognitive error,²⁰ perhaps the most common cognitive error in traditional therapeutic reasoning. It is the aggregation of outcomes data from many prior patients similarly situated with respect to some clinical features that renders comparison with a current patient rational in statistical terms, so long as the current patient meets inclusion criteria for the group of prior patients.²¹

The second approach, promulgation of detailed decision rules for all or most possible contingencies, has the potential, in theory, to substantially limit clinical discretion. Health plans that base their utilization management decisions on sets of clinical practice protocols written by plan managers or acquired from consulting firms²² have tried this approach to some degree, and the difficulties they have encountered point to its limitations. Empirical uncertainty about the outcomes of most medical interventions undermines the perceived legitimacy of health plans' practice (and payment) protocols. Absent scientific support, such protocols are easy to challenge when they become the basis for denial of services. Competing understandings of "appropriate" care leave courts, review panels, and other decisionmakers without evidentiary grounds for choice.²³ Even a much-intensified national program of clinical outcomes research would leave this problem largely in place. Would-be authors of comprehensive payment protocols confront a classic "bounded rationality"²⁴ problem: the awe-inspiring complexity and variability of human physiology renders anticipation, clear definition, and empirical study of most clinical contingencies impossible. The scope of practitioners' discretion is further widened by the subjectivity and inevitable

incompleteness of clinical observation and interpretation. Myriad clinical signs and symptoms are open to varying perceptions and characterizations. Clinical laboratory findings, in conjunction with symptoms and signs, are often susceptible to multiple interpretations. Clinical narratives are selective—and no less centered around a point of view than is an attorney's statement of facts on a client's behalf.²⁵ Even if we could craft a comprehensive set of evidence-based rules for clinical decisionmaking, this subjectivity and incompleteness would make application of the rules a matter of considerable discretion for both the treating physician and the utilization manager.

The third approach, which looks to cloak discretion rather than constrain it, is more closely akin to what actually happens in health care settings. Most of the time, physicians exercise their broad discretion invisibly, making no record apart from clinical progress notes and submissions to utilization reviewers. Only when clinical judgments become the subject of medical conferences, insurance coverage disputes, or legal or regulatory proceedings, do these judgments emerge from the veils of patient confidentiality and professional collegiality. Physicians' practice styles may become known to some degree within their home institutions, but their decisions do not create governing precedent, and their inconsistencies go mostly unnoticed. Utilization management in individual cases is no more transparent. Health plans' coverage decisions are commonly influenced by medical practice and payment protocols, but these protocols are often proprietary. Individual coverage decisions are not reported publicly and do not set precedents that limit discretion in subsequent cases. Inconsistencies between a health plan's utilization management decisions are likely to go unseen except in the rare cases when litigation ensues.

B. Ethical Responses to Clinical Discretion

The pervasive role of clinical discretion in medical practice has long been recognized by medical ethicists. The classic medical ethics answer to the problem of discretion has been the Hippocratic Oath's uncompromising commitment to the well-being of each patient.²⁶ To be sure, as I have observed elsewhere, physicians commonly serve social purposes that are at odds with this commitment's literal meaning. Medical cost containment, public health, and clinical evaluation for legal purposes are among the functions that create tension between this commitment and society's expectations.²⁷ Yet in their everyday clinical work, the overwhelming majority of physicians see undivided loyalty to individual patients as an ethical lodestar.²⁸ Beyond this commitment, and the

concomitant duty to maintain professional competence, the Hippocratic ethical tradition prescribes no rules for the exercise of clinical discretion. Classic medical ethics, rooted in the Hippocratic tradition, is akin to virtue ethics, reliant on the goodness of the doctor as a moral agent, rather than rule-based moral reasoning.²⁹ It parallels the law's reliance on fiduciary obligation in numerous situations marked by a principal's inability to monitor the performance of her agent.³⁰ These approaches entail a common strategy—encouragement of right conduct through interventions designed to insulate agents (including physicians) from bad intentions, especially those engendered by conflicts of interest. They share, therefore, the premise that discretionary judgments arising from right intentions do not, as a rule, warrant additional oversight or constraint.

For the past thirty years or more, the bioethics movement has challenged this benign view of well-intentioned discretion in the medical sphere. Committed to the new paradigm of patient autonomy and concerned about professional paternalism, bioethics commentators have insisted that physician discretion be tempered by the obligation to seek patients' informed consent. The paradigm of patient autonomy relies upon physician disclosure of risks, benefits, and clinical alternatives to give patients meaningful veto power over their doctors' discretion. But as skeptics about this veto power have observed,³¹ physicians have wide latitude to frame clinical alternatives and to shape the contours of disclosure about them. Large variations in clinical practice, within the realm of professional acceptability, translate into vast discretion in the presentation of therapeutic options. Informed consent law's formal equality—its requirement that all material options, and their risks and benefits, be disclosed—is thus subverted by the heterogeneity of medical practice. This occurs openly in jurisdictions that defer to professional standards of materiality in defining disclosure duties and tacitly in jurisdictions that mandate disclosures material to the “reasonable patient.”³² Thus the scope of patients' veto power over their doctors' exercises of clinical discretion is in large measure the product of this discretion. Moreover, patients fearful and dependent in moments of dire medical need are not inclined to assert the veto power they have. To go against the doctor's advice is to go out on one's own, something we are least willing to do when we feel most vulnerable.

C. Race and the Exercise of Clinical Discretion

The substantive content of clinical discretion is thus largely beyond the reach of the ethical paradigms that nominally govern it. Physician discretion remains a wild card in American medicine, ill-constrained by

contractual obligation, legal requirements, or ethical norms. And, absent the exercise of this discretion in identical fashion for members of different racial groups, racial disparities in clinical decisionmaking are inevitable. What accounts for racial and other group differences in the exercise of clinical discretion? Comprehensive assessment of the evidence bearing on this question is far beyond this Article's scope, and a sure answer is well beyond our reach. But partial, provisional answers are possible, and they point the way toward pragmatic interventions that hold out significant potential for the reduction of racial disparities.

To begin with, the weakness of existing constraints on clinical discretion opens the way for beliefs and attitudes that operate beyond the reach of overt institutional and legal rules. Physicians' expectations and suspicions concerning therapeutic compliance and the presence of such co-morbid factors as substance abuse, poor living conditions, and lack of family and social support figure prominently in clinical judgments concerning patients' ability to adhere to risky and costly courses of treatment.³³ Suppositions about patients' truthfulness, self-discipline, laziness or industry, level of suffering, tolerance for pain, and intelligence influence both diagnostic impressions and treatment recommendations.

To the extent that race-related preconceptions affect these expectations and suppositions, racial disparities in clinical judgment ensue. A large, multidisciplinary literature documents and models the formulation and operation of such preconceptions. Cognitive psychologists have analyzed racial stereotypes and prejudice in functional terms, as automatic (or unconscious) category-based responses that conserve the mind's cognitive resources at the price of reduced responsiveness to human individuality.³⁴ Although stereotypes and prejudice can rise to the level of conscious bigotry, they more often operate unconsciously, as automatic cognitive placement of persons into categories with fixed sets of characteristics or as conscious placement of persons into categories with unconsciously surmised characteristics. Psychodynamic and sociocultural models of stereotyping and prejudice likewise recognize the import of unconscious preconceptions.³⁵ Below the waterline of conscious categorization and presupposition, stereotypes and prejudice have free reign, shielded from human self-awareness. Medical judgment informed by such stereotypes is bound to yield racially disparate results, even absent conscious intent.

Beyond this, the attenuation of empathy across racial lines in clinical relationships can engender unconscious devaluation of minority patients' hopes, fears, and life prospects, with invidious consequences for clinical judgment, in the absence of conscious bigotry. Cultural and language

barriers between patients and providers can both amplify this effect and impede communication about symptoms, treatment options, and patient preferences.³⁶ To the extent that the time pressures, sleeplessness, and subservience to authority inherent in medical training imbue an inclination toward automatic, unreflective reactions to clinical situations,³⁷ these features of medical training enlarge the role of stereotypes, prejudice, and barriers to empathy in clinical practice.

Patients' attitudes, beliefs, and capabilities also affect clinical judgment and action in ways that are beyond the control of overt institutional and legal rules. Patients' trust and doubts about medical advice, tolerance for pain and discomfort, attitudes about long-term/short-term trade offs, and levels of social and emotional support influence physicians' recommendations and patients' willingness to accede to them. To the extent that these features correlate with race, they are additional sources of clinical disparity. Some commentators have collapsed these aspects of patients' experiences into a single category of patient "preferences,"³⁸ drawing a dichotomy between such "preferences" and racial discrimination as competing explanations for health care disparities. This reductionistic account overlooks the interactive links between patients' "preferences" and their experiences of discrimination. For many African Americans, doubts about the trustworthiness of physicians and health care institutions spring from collective memory of the Tuskegee experiments³⁹ and other abuses of black patients by largely white health professionals.⁴⁰ This legacy of distrust, which, some argue, contributes to disparities in health care provision by discouraging African Americans from seeking or consenting to state-of-the-art medical services, is thus itself a byproduct of past racism. In more intimate ways, minority patients' negative experiences with care providers can diminish their preferences for robust treatment and thereby engender racial disparities. Physicians' suspicions, stereotypes, negative expectations, and reduced empathy across racial lines can affect patients' feelings about their clinical relationships and thereby dampen patients' interest in vigorous diagnostic and therapeutic measures. Efforts to distinguish patient "preferences" from provider racial discrimination neglect the ways by which patients' negative responses to the latter can profoundly affect the former.

Beyond this dampening effect on minority patients' medical "preferences," health care providers' stereotypes, prejudices, and diminished empathy across racial lines can make it more difficult for minority patients to negotiate clinical bureaucracy. Maneuvering through the catch-22's, cul-de-sacs, and nests of discretion within hospitals and managed care bureaucracies is essential to the accessing of clinical

resources. Clinical caretakers are critical actors in this maneuvering. To the extent that their advocacy efforts are adversely influenced by race-related impressions and lesser personal engagement, racial minority status translates into disadvantage in negotiating medical bureaucracy, and thus into disparate real-world access to clinical services despite formal equality. In addition, to the extent that the discretionary judgments of gatekeeping bureaucrats—e.g. HMO pre-authorization reviewers and hospital staff who prioritize patients on waiting lists for tests and treatments in short supply—are influenced by racial insensitivities and stereotypes, these gatekeepers make a separate contribution to health care disparities. The subjective sense of disempowerment often associated with racial minority status⁴¹ can further widen the disparities that ensue from clinical administration. People who feel less able to assert their needs tend either to do so with less vigor or, more invidiously, to feel bitter, even resentful, and to act in a manner that conveys this bitterness, thus rendering clinical administrators less empathic.

III. INSTITUTIONS, INCENTIVES, AND THE LAW

If beliefs and attitudes beyond the controlling authority of institutional and legal governance play such a large part in the racially disparate exercise of clinical discretion, what role, if any, do health care institutions and law have in engendering health care disparities? I submit that this role is large, and that organizational design, economic incentives, and the legal and regulatory environment interact perniciously, in unexamined ways, with the psychological factors I have discussed to potentiate disparities in clinical judgment. My starting point for making this claim is the unpalatable truth that setting limits on the care we provide is a crucial task for clinical institutions and health law. Writing for a unanimous Supreme Court last year in *Pegram v. Herdrich*, Justice David Souter put this point bluntly with regard to managed care, declaring that “whatever the HMO, there must be rationing and inducement to ration” and that “rationing necessarily raises some risks while reducing others”⁴² The need for limit-setting is no less for other health plans that must operate within a budget, whether fiscal constraints are imposed by competitive pressures in the health insurance marketplace or voters’ limited tolerance for the tax burden of publicly funded medical coverage.

A. Fee-for-Service Payment and Demand-Supply Mismatches

When physicians are paid on a fee-for-service basis and managed care is not a factor, demand-side limit-setting plays a minimal role. Clinical

caretakers committed to the Hippocratic ethic of undivided loyalty to individual patients and aware of their insured patients' low out-of-pocket costs are motivated to demand (on behalf of their patients) virtually all services with potential benefits that outweigh clinical risks. To be sure, the psychological factors I have discussed, including unconscious stereotyping, prejudice, and reduced empathy across racial lines, may influence the weighing of clinical benefits and risks, generating demand-side racial disparities. But under fee-for-service physician compensation, supply-side constraints on care probably play a larger role in engendering racial disparities. Supply-side constraints arise from limited physician time (due to barriers to entry maintained by the medical profession),⁴³ restrictions on hospitals' ability to raise capital for new facilities and equipment,⁴⁴ regulatory and market-driven constraints on hospital payment rates, and regulatory programs (especially "Certificate of Need" requirements) that limit hospital investment in new facilities, services, and equipment.⁴⁵ These supply-side constraints, alongside generous insurance coverage, create a myriad of demand-supply mismatches within hospitals⁴⁶ and other clinical institutions.

These demand-supply mismatches have great potential to generate racial disparities in care because of the interplay between the mechanisms that mediate these mismatches and the nature of race-related disadvantage within clinical institutions. As the economist Jeffrey Harris has observed, excess demand for a hospital's services creates multiple internal queues for services.⁴⁷ Absent bright-line, easy-to-apply criteria for prioritizing among patients in a queue, the politics of personal influence and professional hierarchy shapes resource allocation. Attending physicians with the professional stature and/or political skills to push their patients to the head of the queue in clinically ambiguous situations will do so on behalf of those to whom they feel most committed. Conversely, housestaff and less influential attending physicians will have more difficulty moving their patients up the queue. Moreover, treatment of patients in hospital clinics and other settings characterized by rapid staff turnover and lack of continuity of care renders committed physician advocacy on behalf of these patients less likely, whatever the professional standing and influence of their attending doctors. Patients cared for by high-status physicians in settings that support continuity of clinical relationships thus have preferred access to services when demand-supply mismatch conditions exist.

To the extent that people of color are more likely to see low-status providers,⁴⁸ who are less able (or inclined) to maneuver effectively within clinical bureaucracies on their patients' behalf, racial disparities in care are

likely to ensue from these status disparities. More research into which patients tend to access the most (and least) elite physicians—and into whether these differences give rise to disparities in clinical services received—is much needed. But it has long been recognized that hierarchies of professional stature and commitment to patients within clinical institutions parallel hierarchies of patient socio-economic class.⁴⁹ Well-off and influential patients tend to link up with elite academic and private physicians, to sustain their relationships with these physicians, and to benefit from these physicians' sponsorship and advocacy in hospital and other institutional settings.⁵⁰ Middle-class patients tend to access a lower level of sponsorship and advocacy, from private physicians without elite status and influence.⁵¹ Working poor and unemployed patients, especially the uninsured, tend to find their way to a bottom tier of public clinics staffed by rotating house officers and salaried attendings with little institutional cache.

Social networks, family contacts, and levels of assertiveness can be as important as financial wherewithal in distributing patients across these echelons of professional status, sponsorship, and advocacy. Little is known about the links between these factors and race, and about the extent to which race (and its social consequences)—divorced from economic status—pushes patients up or down across these echelons. But evidence suggests that members of disadvantaged racial minority groups are more confined than whites (of similar economic status) in their range of social contacts and less inclined to challenge professional authority.⁵² If this is the case, it would hardly be surprising were it to be shown that African Americans and other people of color find their way into the health care system at lower strata of professional sponsorship and advocacy than can be accounted for by economic class alone. And to the extent that lower levels of sponsorship and advocacy mean lesser access to services in short supply, racial disparities in care are to be expected. More speculatively, feedback from the supply side to the demand side may aggravate these disparities. Aware of chronic demand-supply mismatches, physicians, especially those at lower status levels, might modulate their clinical orders to bring demand more into line with supply constraints.⁵³

B. Medical Tort Law and Clinical Discretion

The law of health care provision has been largely hands-off, in practice, concerning the links between clinical discretion and racial disparities. Medical malpractice law, in theory, prescribes a unitary level of care, regardless of health insurance status or ability to pay.⁵⁴ But tort doctrine has long deferred to physician standards of care, under the sway

of the lingering fiction that there is a single “correct” standard, discernable from physician-experts through the adversary process. Disparities in clinical resource use ensuing from physician discretion and the influences I have just discussed tend to fall within the bounds of tacitly accepted clinical variation. Lower intensity care provided to a minority patient can thus typically be defended as consistent with one or another widely accepted standard of care. A tort plaintiff can attack care provided pursuant to a particular standard by pointing to an alternative standard and relying upon expert testimony to argue that this alternative should have been followed. But so long as the defense can marshal its own expert to support the adequacy of the care provided, the plaintiff’s need to carry the burden of proof presents a daunting obstacle to success. Medical malpractice cases commonly turn clinical practice variations into battles of the experts, unresolvable on rigorous empirical grounds, over which standard constitutes “reasonable care.” Absent the high-quality data about efficacy of alternative approaches that would be needed to resolve clinical practice variations in the first place, proof of causation-in-fact presents another large barrier to plaintiffs. Technologically less intensive approaches often cannot be shown to yield inferior clinical outcomes. Moreover, even when there is strong empirical support for the superior efficacy of one approach compared to another, the medical tort system sends a weak behavioral signal. Only a small proportion of arguable errors of clinical judgment—arguable based on empirical grounds for preferring one approach to another—result in medical malpractice suits.⁵⁵ Even smaller proportions yield monetary settlements or judgments, and poor people and members of disadvantaged minority groups are less likely than other Americans to sue their doctors.⁵⁶

C. Medicaid and Programmatic Fragmentation

Other sources of law bearing on the behavior of doctors and clinical institutions have been similarly hands-off with regard to racial disparities. The Medicaid program’s meager payment rates for doctors and hospitals have consigned this program’s poor, disproportionately minority beneficiaries to largely separate, often segregated systems of hospital and neighborhood clinics,⁵⁷ with their own norms of medical practice, inevitably shaped by their tight resource constraints. The reluctance of private physicians to accept Medicaid rates as payment in full has not only kept Medicaid patients out of private doctors’ offices; it has consigned them to “ward” or “community service” status as inpatients, cared for primarily by housestaff as opposed to private attendings.⁵⁸ Congressional repeal of the Boren Amendment, which required Medicaid payments to

doctors and hospitals to be “reasonable and adequate”⁵⁹ and gave health care providers a federal cause of action against state Medicaid programs,⁶⁰ has entrenched Medicaid’s low payment scales and largely separate systems of care. More research is needed on the question of how, if at all, standards of care within these separate systems differ from mainstream medical practice—and on whether racial disparities occur within the Medicaid program. But given the pervasiveness of clinical practice variations in American medicine and the pressure on practitioners in any system to adapt their clinical judgments and conduct to the system’s resource constraints, it would be surprising if practice within Medicaid-oriented systems were not less technology-intensive than mainstream care. And, given the segregation of Medicaid-oriented systems from each other, by neighborhood and community and therefore, in practice, by race, it would be surprising if racial disparities within the Medicaid program did not ensue.⁶¹ As I will discuss later,⁶² the recent shift in federal policy toward the easy granting of statutory waivers to permit start-up of Medicaid managed care programs is creating new possibilities for clinical fragmentation and disparity.

D. EMTALA

Judicial interpretation of the federal Emergency Medical Treatment and Active Labor Act (EMTALA)⁶³ has drained its force as a deterrent to disparate treatment in the emergency room. The Act requires hospitals that operate emergency rooms and participate in Medicare or Medicaid to screen all emergency room patrons for “emergency medical conditions” regardless of their ability to pay, to provide stabilizing treatment for such conditions, and to refrain from discharging patients or transferring them to other facilities on economic grounds.⁶⁴ Federal appellate panels in several circuits have held that EMTALA’s mandatory emergency screening examination need not meet national standards of care, but need only measure up to the screening hospital’s regular practice.⁶⁵ The practical consequences for plaintiffs⁶⁶ are enormous. Deprived of the opportunity to search nationally for experts to testify about the appropriate standard of care, they must look to physicians familiar with emergency room screening practice at the hospital they intend to sue—or to other evidence of this hospital’s emergency room procedures. The resulting “code of silence” problem is obvious: avoidance of the “code of silence” barrier was a principal reason for the shift from community to national standards of care in medical malpractice law. The cursory evaluation and transfer or discharge of members of disadvantaged minority groups—whether for financial reasons, racial animus, or unconscious prejudice—is thereby

rendered more likely to occur with impunity. State laws mandating emergency room screening and stabilizing treatment—a topic beyond my scope in this Article—have generally been construed and applied with similar permissiveness.⁶⁷

E. The Unfulfilled Potential of Title VI

In theory, Title VI of the Civil Rights Act of 1964 has enormous potential as a tool for reduction of racial disparities in health care provision. Title VI bars discrimination based on race by all who receive “federal financial assistance” and extends beyond intentional discrimination to reach many facially neutral practices with disparate racial impact. Title VI has achieved some of its potential, most notably through enforcement action by the U.S. Department of Health and Human Services (DHHS) and DHHS’s predecessor agency⁶⁸ against hospitals’ employment of such discriminatory practices as denial of admitting privileges to African-American physicians,⁶⁹ refusal of admission to patients lacking attending physicians with staff privileges, high prepayment requirements for black patients, and discriminatory routing of ambulances.⁷⁰ In these cases, the DHHS Office of Civil Rights has compelled such measures as revision of requirements for staff privileges, elimination of prepayment requirements, and changes in ambulance routes.⁷¹ Title VI’s coverage of entities that receive “federal financial assistance” encompasses all hospitals that receive Medicare or Medicaid payments, making its potential reach remarkably broad.

Yet more might have been achieved, had more been attempted. The federal regulations promulgated pursuant to Title VI did not offer detailed compliance instructions to health care institutions⁷² and, more significantly, held that Medicare’s payments to physicians do not constitute “federal financial assistance.”⁷³ The later, fateful decision put private physicians out of Title VI’s reach, even though virtually all other federal payments to private actors are treated by the regulations as “federal financial assistance,” triggering Title VI protections.⁷⁴ Treating physicians’ income from Medicare as “federal financial assistance” would have given DHHS a powerful civil rights enforcement tool, applicable not only to racial disparities in the care provided to Medicare patients, but also to disparate treatment of non-Medicare patients by physicians who accept Medicare. Since most physicians in private practice accept Medicare,⁷⁵ and since physicians remain the key decisionmakers with respect to use of hospital resources and services, extending Title VI’s reach to Medicare coverage of physician services would subject most of the private health care sector to Title VI enforcement.

Detailed reviews of Title VI's application to medical care have been performed by others.⁷⁶ I will limit myself here to the observation that the principal, still unfulfilled promise of Title VI in the health sphere lies in translation of what is now known about racial disparities in health care provision into practices and policies that reduce these disparities, especially when they can be shown to contribute to differences in health status. More specific regulatory guidance (grounded in findings from empirical research), more robust DHHS monitoring and enforcement, and application of Title VI to private physicians would represent important steps in this direction. Title VI's reach beyond intentional discrimination to policies with disparate racial impact enables civil rights enforcement to make use of institution-specific statistical evidence of disparities in health care provision. Such evidence may suffice to state a prima facie case of discrimination, requiring a health care provider to justify policies and practices that result in racially disparate clinical decisions.⁷⁷ Proof of institution-specific disparities—and of causal links between such disparities and particular policies and practices—will pose daunting challenges. Litigation involving statistical evidence of clinical disparities is likely to be expert-intensive and hence costly.⁷⁸ But the ongoing revolution in electronic clinical record keeping is making such evidence increasingly accessible to civil rights enforcement authorities.

The promise of such evidence would be much greater were private parties permitted to seek legal relief, under Title VI, from policies with disparate racial impact. But in April 2001, in *Alexander v. Sandoval*,⁷⁹ the U.S. Supreme Court held that Title VI did not create a private right of action concerning policies with disparate impact, absent discriminatory intent. Title VI's future as a health policy tool will thus be shaped largely by the federal executive branch, through its civil rights enforcement policies.

F. Clinical Role Conflict and Patient Distrust

Beyond all this, the law of health care provision has taken a stance of not-so-benign neglect toward features of American medicine that invite distrust among disadvantaged minorities. Law, in action, tolerated Tuskegee, or at least failed to prevent it.⁸⁰ The law today tolerates physician participation in an array of activities that are at odds with the Hippocratic commitment of undivided loyalty to patients⁸¹ and that especially effect disadvantaged groups. The prison doctor, whose therapeutic role is often confused by conflicting duties to keep order⁸² and determine criminal responsibility, is hardly a benign figure in the lives of inmates, and African Americans are disproportionately represented in U.S. prisons. The

physician who both attends to the medical needs of Immigration and Naturalization Service (INS) detainees and prescribes drugs to sedate those who resist deportation⁸³ is a similarly problematic figure in the eyes of many Latinos and others who have had personal or family experience with INS detention. Academic physicians overly focused on the training and research purposes of patient encounters, and psychiatrists at state mental hospitals who prescribe high neuroleptic doses to maintain order, are other examples to which the most disadvantaged Americans are disproportionately exposed. The likely result of the law's sometimes overt and other times tacit acceptance of such role conflict is further erosion of trust—and of willingness to go along with robust, state-of-the-art clinical interventions when well-meaning physicians make them available.

IV. THE MANAGED CARE REVOLUTION

Managed care has introduced new institutional dynamics that both contribute to racial disparity in health care provision and create openings for progress toward eliminating some disparities. Prospective utilization management by administrators remote from the bedside, use of financial incentives to influence physician judgment, and the proliferation of differently designed coverage options have large implications for clinical discretion and thus for inter-group disparities. The law has responded sluggishly to these market-driven developments, which are occurring too quickly for courts and regulators to keep pace.⁸⁴

A. Prospective Utilization Management

Utilization management by remote case reviewers has created new possibilities for disparity in health care provision. To the extent that prospective utilization review applies detailed coverage rules in a standardized fashion (whether or not the rules are well grounded in scientific evidence of clinical efficacy), it has the potential to make clinical care more uniform. But the subjectivity and ambiguity of clinical situations make such standardization elusive, and the complexity and individuality of human pathophysiology render rules for all contingencies impossible.⁸⁵ The result is that success in competition for resources within a health plan depends in large part on committed, effective advocacy by clinical caretakers—an asset that, for reasons discussed earlier,⁸⁶ members of disadvantaged minority groups are less likely than others to have. The outcomes of competition for resources within a plan also turn on utilization managers' discretion. There has been almost no research into subjective influences on utilization reviewers' decisions in ambiguous cases.

But it seems likely that empathy with particular patients (as portrayed clinically by their caretakers) and the colder calculus of who is most likely to appeal (and ultimately to sue)⁸⁷ each play roles. Both of these factors favor the affluent, the educated, and the most advantaged racial and ethnic groups. Research is much needed into how members of disadvantaged minority groups fare in comparison with others at accessing services and resources within particular health plans.

B. ERISA Immunity for Utilization Management

Health plans' immunity from medical malpractice suits for their utilization management decisions⁸⁸ has empowered preauthorization reviewers to exercise their discretion unconstrained by law in many states. A series of federal appellate court rulings in the 1990s construed the Employees Retirement Income Security Act (ERISA) to preempt general state tort and contract law bearing upon administration of benefits by employer-provided health plans.⁸⁹ These decisions, moreover, interpreted ERISA to bar federal actions for consequential damages, closing the door to meaningful tort liability.⁹⁰ But over the past several years, a number of states have enacted laws imposing a variety of safeguards and remedies, including independent medical review of disputed claims denials, and a split between the circuits emerged in 2000 concerning whether these statutes circumvent ERISA preemption.⁹¹ As this Article goes to press, the future of health plan accountability for denial of benefits is uncertain. Congressional compromise this year on so-called "Patients' Bill of Rights" legislation could redefine now-entrenched battle lines, or the Supreme Court could intervene to clarify this confusing area.

C. Physician Financial Incentives as a Management Tool

A decade ago, proponents of managed care envisioned a world of competing, vertically integrated health plans, able to control costs through bulk purchasing power and administrative authority over clinical decisions.⁹² But by the end of the 1990s, a very different medical marketplace had emerged, characterized by what one close observer calls "virtual integration"—rapidly shifting contractual alliances between health plans (which eschewed vertical integration as insufficiently adaptable to changing conditions) and hospitals and physician groups.⁹³ A striking feature of this new managed care marketplace is its wholesale shift from the paradigm of cost control via centralized management of clinical decisionmaking to an alternative model—devolution of financial risk, and thus responsibility for cost control, to practicing physicians.⁹⁴ Economic

rewards for frugality and penalties for pricey tests, treatments, and referrals have become lodestars for contemporary clinical practice.⁹⁵ The result has been greatly increased reliance on the discretion of gatekeeping clinical caretakers to set limits and manage scarcity. This means more room for free play of the cognitive, affective, and social and cultural factors discussed earlier, which influence clinical discretion in racially disparate ways. It also makes medical resource allocation more of a function of physicians' suspicions and fears about who will protest, if denied a test or treatment, and who might sue. By dispensing with the bureaucratic inefficiencies and irritants of remote utilization review, the managed care industry is forgoing this latter method's limited prospects for standardization in favor of an approach that risks abdicating the pursuit of clinical consistency.

Financial incentives in themselves are not pernicious; moreover, they are inevitable. But the simple, open-ended incentives to withhold care that many managed health plans now employ sacrifice opportunities for supporting quality and rewarding equity within budgetary constraints. One can imagine more nuanced incentive schemes that reward measurable efficacy and engagement with patients as well as financial savings. Payment tied to appropriate health promotion and disease screening practice,⁹⁶ patient satisfaction, and measurable treatment successes,⁹⁷ as well as to frugality, has the potential to reduce racial disparities in care by pushing physicians toward colorblind benchmark practices. In this regard, last year's U.S. Supreme Court holding, in *Pegram v. Herdrich*,⁹⁸ was dismaying for its categorical rejection of efforts to read regulatory constraints on physician incentives into ERISA's ambiguous language.⁹⁹ But it is possible that consumer unhappiness over financial rewards to physicians for withholding care could push health plans toward these more nuanced incentive programs through market means.

D. Fragmentation and Health Care Disparities

We have not yet achieved the health care system some erstwhile market advocates urge,¹⁰⁰ characterized by multiple tiers of medical coverage offering overtly different, contractually defined standards of care. Such a regime might be more honest in its acknowledgment of clinical disparity than the system we now have. Health insurance contracts continue to promise "medically necessary" care, without overt reference to economizing or to cost-benefit tradeoffs. Yet multiple coverage options offering different benefits packages, degrees of choice of provider, levels of access to elite physicians and hospitals, and levels of preauthorization review and financial incentives to physicians to practice frugally segment

today's medical marketplace—by personal wealth and health status as well as consumer and employer preference. Managed care plans comprised largely or entirely of Medicaid recipients and other poor Americans have expanded coverage for the neediest but further segmented the market. We have only sketchy empirical knowledge about the differing levels of intensity of care provided by low-end versus high-end health plans, and it has not been shown that low-end coverage, by itself, produces inferior medical outcomes.¹⁰¹ But it is reasonable to surmise that, all else being equal, less generous coverage predicts lower intensity of care, since care must be provided within a budget. And it is reasonable to surmise, therefore, that population groups disproportionately represented in lower-end plans receive, on average, a lower intensity of care. Studies of racial disparity in health care provision have attempted to control for insurance status broadly categorized (e.g. Medicare, Medicaid, or private coverage), but they have not broken medical coverage down into categories along this segmented spectrum. They thus leave open the possibility that proven racial disparities in care result, to some degree, from the disproportionate presence of disadvantaged groups in lower-end plans.

Little is known about the distribution of disadvantaged minority groups across this country's fragmented medical marketplace, beyond the fact that they are disproportionately represented in Medicaid-only plans. But we do know that fragmentation of health care financing and provision engenders the development of disparate clinical practice norms, arising from distinct institutional cultures and provider and patient characteristics, as well as from different levels of fiscal constraint. The extreme example of South African medicine under apartheid illustrates the point. The architects of apartheid built an almost bizarrely fragmented health system by intentional design, creating multiple, parallel institutions, with different per capita resource constraints, for different, officially recognized racial groups.¹⁰² Within these parallel institutions, sharply different clinical practice and resource allocation norms emerged. Individual clinicians, working, for the most part, in only one or a few settings, could adhere to the norms "appropriate" to their employment settings without having to confront, in day-in, day-out fashion, the very different norms applicable in others. Fragmentation in American health care does not come close to this disturbing extreme, and structural features of the U.S. health care marketplace protect against a large movement in this direction. The phenomenon of "virtual integration," for example, entails participation by most providers—doctors and hospitals—in multiple health plans,¹⁰³ and human cognitive limits and the complexity of medical practice make it unlikely that individual clinicians will be able to learn and adhere to

multiple, dramatically different standards of care for differently insured patients.¹⁰⁴ Still, the South African caricature is a useful warning about the risks involved, from a racial and social justice perspective, in a system of health care coverage choice that devolves too far toward market and administrative fragmentation.

V. SOME RECOMMENDATIONS

Institutional design and legal governance cannot, by themselves, meet the moral challenge posed by racial disparities in American health care provision. Efforts to intervene at the psychological and social levels, in the course of medical education, apprenticeship, and ongoing professional life, are essential if the stereotypes and prejudgments that engender racially disparate clinical judgments are to be effectively addressed. Patient education and reassurance efforts that take great care to avoid even the appearance of “blaming the victim” are also vital. Yet institutions and law make a large difference. They can potentiate, or attenuate, the operation of the psychological processes that produce disparity. I will conclude with some brief suggestions about how our health care institutions and law might respond pragmatically to the problem of racial disparity even as they pursue other important policy goals.

A. Rule-Based Cost Control

To the extent possible, given the gaps in our knowledge about medical care’s efficacy and the impossibility of anticipating all clinical contingencies, medical limit-setting should be based on rules. The classic advantages of rules over general, discretionary standards—consistency, predictability, and at least the appearance of disinterested objectivity—make detailed rules preferable from the point of view of reducing racial disparities in medical care. Pragmatic balances must be sought between these advantages of rules and their rigidities, and in this regard there may be tensions between the goal of reducing racial disparities and the virtues of greater clinical flexibility. Requirements by private accrediting entities and state regulatory bodies that health plans’ clinical practice protocols be published, with supporting evidence and argument, and thus open to professional and consumer review would aid in the deliberative balancing of the virtues of rules and discretion. Clinical rules that are not backed by evidence and argument should not be entitled to deference in administrative or legal proceedings that involve challenges to health plans’ application of such rules. But where rules do have empirical support, even if the evidence is at best debatable, administrative and legal

decisionmakers should give substantial weight to the social importance, in a racially and culturally diverse nation, of making agonizing allocative choices in a manner that achieves some consistency in appearance and practice.

B. The Architecture of Physician Financial Incentives

Pursuit of cost control the crude way, by simply paying physicians more to do less, makes gatekeeping clinical caretakers' stereotypes and selective empathy into medical resource allocation policy at the macro level. By raising the social stakes attached to clinical discretion, it amplifies the social impact of these stereotypes and failures of empathy. To the extent that health plans abdicate the management of care by abandoning efforts to craft and implement reasonable, evidence-based clinical practice protocols, these stereotypes and failures of empathy can play out, unfiltered, as plan policy. Economic incentives, either to provide more or fewer services, are unavoidable, and blanket condemnations of all incentives are naïve. But some limits on incentives to withhold treatment are desirable to control the pressure on physicians to abandon their fiduciary commitments to patients¹⁰⁵ and allow their worst reactions to racial difference to come to the fore.¹⁰⁶ The U.S. Supreme Court's decision in *Pegram v. Herdrich* foreclosed federal restrictions on physician incentives under ERISA, but it left room for state limits on rewards to physicians for withholding care.¹⁰⁷

More finely crafted physician incentives can have a positive role in efforts to reduce racial disparities in care. Greater economic rewards for time spent engaging patients and their families can contribute to overcoming barriers of culture, communication, and empathy, and the cost of these incentives can be covered by reducing the large premium paid to physicians for time spent performing procedures. Insurance coverage for the modest cost of language translation services can yield large improvements in communication (and physician empathy) for some patients. Payment schemes that reward measures of patient satisfaction and confidence would further encourage the bridging of barriers related to racial difference. Incentives to adhere to evidence-based protocols for frugal practice and to engage in age and gender appropriate disease screening would encourage efficient, quality care generally and penalize race-related deviations. Payment linked to favorable clinical outcomes, where reasonably measurable—e.g. control of diabetes, asthma, and high blood pressure—would provide additional encouragement. Industry movement toward more nuanced incentive schemes along these lines could be catalyzed by private accrediting bodies, encouraged by business

and professional leaders, and even initiated by public payers.

C. Strengthening Doctor-Patient Relationships

The connection between a patient's access to clinical resources within a hospital or health plan and her doctor's stature, skill, and commitment as an advocate underscores the importance of strengthening minority patients' bonds with physicians positioned (and willing) to play the advocate's role vigorously. It may not be realistic to insist on an end to the wealthiest, most influential patients' superior ability to gain access to the clinical judgment and institutional clout of the most elite physicians. Yet we can aspire to the goal of ensuring that every patient, whether insured privately or publicly, through Medicare or Medicaid, has a sustained relationship with an attending physician, not merely a house officer, who is able to navigate the health care bureaucracy effectively on the patient's behalf. Federal and state performance standards for Medicaid managed care plans should include minimum requirements for the stability of patients' assignments to primary care providers¹⁰⁸ (and these providers' accessibility),¹⁰⁹ reasonable maximum patient loads per primary physician, and minimum time allotments for patient visits. Regulations governing health plans' participation in Medicare should include similar standards, as should private accrediting bodies' prerequisites for all health plans. More controversially, patients from historically disadvantaged groups might be given the option to select primary care providers from similar backgrounds, since ample evidence shows that such concordance is associated with greater patient satisfaction and more consistent provision of preventative care.¹¹⁰ On the other hand, the explicit color-consciousness this would entail risks entrenching the racial biases to which this remedy responds. At a minimum, evidence of the clinical benefits of racial concordance weighs in favor of robust commitment to affirmative action in medical school admissions, residency recruitment, and professional hiring.

D. "De-Fragmentation" of Health Care Financing and Delivery

The disproportionate presence of members of disadvantaged racial minorities in lower-end health plans may be a major source of racial disparities in health care provision, since efforts to control for insurance status in studies of clinical disparity have not taken detailed account of variations among health plans.¹¹¹ Research into the distribution of racial minorities across the fragmented American health care marketplace, the differences in intensity of care between lower and higher end health plans, and the relationship (if any) between these differences in intensity and the

quality of clinical outcomes should be a national priority. In the meanwhile, it is reasonable to surmise that efforts to reduce the socio-economic segmentation of the medical marketplace would probably diminish racial disparities in service provision. Fragmentation engenders different clinical cultures, with different practice norms, tied to varying per capita resource constraints.

Concrete regulatory steps can limit such fragmentation. Movement toward managed care as a tool for both containing the Medicaid program's costs and extending its coverage reach can be accompanied by a requirement that participating health plans enroll some minimum number (expressed in percentage terms) of private subscribers. Plans that participate in Medicaid (or other public programs for the poor and near-poor) can be required to contract with hospitals and physician networks that serve minimum percentages of patients who purchase coverage without public subsidies. At times, regulatory restraint may be in order. State legislators should resist doctors' efforts to win regulatory protection from health insurers' insistence that providers accept patients from all plans an insurer offers. Health insurers' bargaining power on this issue is a force against fragmentation. Were physicians able to pick from among the varied coverage "products" each firm offers—by limiting the numbers of patients they accept from low-end plans or by simply refusing to participate in these plans—they would self-segregate toward different medical marketplace segments, making segment-by-segment differences between practice styles more pronounced.

The question of how much fragmentation is too much is ultimately political, tied to the larger debate over the relative importance of equity, liberty, and reward for enterprise in American life. As such, this question is beyond my scope here. But the economic segregation of Medicaid patients into a bottom-end system of Medicaid-only HMOs, decrepit public hospitals, and separate public clinics strains the lower boundaries of decency. Medicaid's statutory promise, in 1965, of mainstream care for the poorest Americans can only be kept through national and state commitments to supply the resources needed for these Americans to buy into the medical mainstream. And for America's more than forty million uninsured, to whom no such promise has yet been made, the indecency is patent.

CONCLUSION

The approaches to institutional design and legal governance that I have urged cannot, by themselves, eliminate racial disparities in health care provision. Myriad presuppositions, stereotypes, and other

psychological barriers to empathy and understanding influence clinical judgment in ways that are beyond the reach of organizational and legal arrangements. Yet institutions do matter. Cost-control that is rule-based when empirically feasible; financial rewards for patient satisfaction, health promotion, and favorable outcomes; and efforts to encourage stable doctor-patient relationships and resist market segmentation along race-correlated lines promise to channel clinical discretion in ways that reduce racial disparity. Health plans and regulators can accomplish much along these lines while pursuing other policy goals, including efficiency and quality.

The case for institutional and legal steps toward reduction of racial disparities in clinical care is morally compelling. On the other hand, the targeting of disparities in health care decisionmaking without a corresponding effort to reduce racial differences in health status and access to medical services raises painful questions about health policy priorities. Should we take pragmatic advantage of the political “moment” by waging a vigorous campaign against disparities in medical decisionmaking while tolerating, for a time, differences in health status and medical care access? Are racial disparities in medical care provision important apart from their impact on health status, or should their import be assessed in instrumental terms, based purely on their health impact? And in a society that accepts, as a philosophical matter, many forms of inequality that arise from market outcomes, what are the moral prerequisites for public intervention to ameliorate health-related racial disparities that spring from economic inequality?

These questions merit deep reflection and robust public debate. But a larger implication of the overwhelming evidence of racial disparity in health care provision is clear. This evidence constitutes indisputable proof that the national task of racial healing is not nearly finished—that tacit, often unconscious stereotyping, prejudice, and selective empathy persists, indeed pervades our social life and damages many Americans physically as well as spiritually. In the health sphere, as in other areas of our national life, the most pernicious “racial profiling” is that which we do unreflectively, even unconsciously, as a matter of routine.

References

1. Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618 (1999).
2. These physicians, who were not told that the purpose of the study was to assess the influence of race (and sex) on clinical decisionmaking, were shown scripted, videotaped interviews of hypothetical patients; given additional clinical information about their "patients;" then asked to make follow-up clinical recommendations. *Id.*
3. Lisa M. Schwartz et al., *Misunderstandings About the Effects of Race and Sex on Physicians' Referrals for Cardiac Catheterization*, 341 NEW ENG. J. MED. 279 (1999).
4. The editors concluded, in a reply to letters critical of the Schulman paper's conclusions, that "the evidence of racism and sexism in this study was overstated" by the paper's statistical presentation of the study's findings. Gregory D. Curfman & Jerome P. Kassirer, *Race, Sex and Physicians' Referrals for Cardiac Catheterization (the editors reply)*, 341 NEW ENG. J. MED. 287 (1991). The Journal's editors, it should be noted, did not deny the existence of racial disparities in American health care.
5. John Z. Ayanian, *Race, Class, and the Quality of Medical Care*, 271 JAMA 1207 (1994); Durado D. Brooks et al., *Medical Apartheid*, 266 JAMA 2746 (1991); Robert M. Mayberry et al., *Racial and Ethnic Differences in Access to Medical Care*, 57 MED. CARE RES. & REV. 108 (Supp. 2000); Gregory Pappas et al., *The Increasing Disparity in Mortality Between Socioeconomic Groups in the United States, 1960 and 1986*, 329 NEW ENG. J. MED. 103 (1993).
6. HOUSE COMM. ON LABOR, HEALTH & HUMAN SERV., & EDUC. APPROPRIATIONS, 196TH CONG., REPORT TO ACCOMPANY H.R. 3064, at 1 (2000).
7. AM. MED. ASS'N, AMA TEAMS UP WITH U.S. SURGEON GENERAL SATCHER TO ELIMINATE DISPARITIES OF CARE AND IMPROVE COUNTRY'S HEALTH (2000); AM. PUB. HEALTH ASS'N, INFLUENTIAL AND DIVERSE LEADERS JOIN STEERING COMMITTEE OF APHA/HHS CAMPAIGN TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES (2000); U.S. DEP'T OF HEALTH & HUMAN SERV., TRANS-NIH COLLABORATION WITH NIOSH INITIATES STUDIES OF RACIAL AND ETHNIC DISPARITIES IN HEALTH, available at <http://raceandhealth.hhs.gov/sidebars/sbwhats30.htm> (last visited Apr. 24, 2001).
8. Robert J. Blendon et al., *Access to Medical Care for Black and White Americans*, 261 JAMA 278 (1989); Council on Ethical and Judicial Affairs, *Black-White Disparities in Health Care*, 263 JAMA 2344 (1990) [hereinafter *Black-White Disparities*]; Council on Scientific Affairs, *Hispanic Health in the United States*, 265 JAMA 248 (1991); Arline T. Geronimus, *Excess Mortality Among Blacks and Whites in the United States*, 335 NEW ENG. J. MED. 1552 (1996); Pappas et al., *supra* note 5, at 103.
9. Marsha Lillie-Blanton & Thomas Laveist, *Race/Ethnicity, the Social Environment, and Health*, 43 SOC. SCI. MED. 83 (1996).
10. See, e.g., Leigh Hopper, *Rice, Baylor, UT-Houston Join to Study Social Causes of Sickness*, HOUS. CHRON., Apr. 8, 1999, at A1; *Racial and Ethnic Disparities in Health Persist between Majority and Minority Americans, Says*

Patient Care(R) Magazine, PR NEWSWIRE, May 15, 2000, Financial News.

11. There is a strong relationship between race/ethnicity and the lack of health insurance in adults. Thirty-one percent of low-income (less than 200% of the Federal Poverty Level), white non-Hispanics are uninsured, accounting for 50% of the low-income uninsured and 31% of the entire uninsured population. Black non-Hispanics are uninsured at a rate of 34%, account for 16% of the low-income uninsured, and comprise 50% of the uninsured population as a whole. Fifty-three percent of low-income Hispanics lack health insurance. Low-income Hispanics account for 29% of the low-income uninsured and 19% of the uninsured population. John Holahan & Niall Brennan, *Who Are the Uninsured?* (URBAN INSTITUTE, NEW FEDERALISM: NATIONAL SURVEY OF AMERICA'S FAMILIES, NO.14) (2000), at http://newfederalism.urban.org/html/series_b/b14/b14.html (last visited Apr. 24, 2001).

12. Some market-oriented commentators argue openly for judicial recognition of multiple tiers of health care quality, tied to insurance contract terms mandating different cost-benefit trade-offs and levels of access to technology—and thus linked to consumers' ability to pay. RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTHCARE?* (1997); CLARK C. HAVIGHURST, *HEALTH CARE CHOICES OF HEALTH REFORM* (1995). Such an approach to medical tort law and the interpretation of insurance contracts would legitimize racial disparities in physician judgment that arise from

differences in medical coverage.

13. There is ample evidence, epidemiological and biological, of connections between psychosocial stress and a variety of illnesses, including cancer and cardiovascular disease. *See generally* Johan Denollet, *Personality as Independent Predictor of Long-term Mortality in Patients with Coronary Heart Disease*, 347 LANCET 417 (1996); Dorthe Hansen et al., *Serious Life Events and Congenital Malformations: A National Study with Complete Follow-up*, 356 LANCET 875 (2000); David Spiegel, *Psychosocial Intervention in Cancer*, 85 J. NAT'L. CANCER INST. 1198 (1993). Neuroendocrine pathways that suppress immune function, increase blood pressure, and influence metabolism of cholesterol and other potentially harmful substances are thought to be responsible. *See generally* E.J. Burkner et al., *Serum Lipids, Neuroendocrine, and Cardiovascular Responses to Stress in Men and Women with Mild Hypertension*, 19 BEHAV. MED. 155 (1994); M. Fredrikson & J.A. Blumenthal, *Serum Lipids, Neuroendocrine and Cardiovascular Responses to Stress in Healthy Type A Men*, 34 BIOL. PSYCHOL. 45 (1992).

14. *E.g.*, Arline T. Geronimus, *Black/White Differences in the Relationship of Maternal Age to Birthweight: A Population-Based Test of the Weathering Hypothesis*, 42 SOC. SCI. MED. 589 (1996); Arline T. Geronimus, *The Weathering Hypothesis and the Health of African-American Women and Infants: Evidence and Speculations*, 2 ETHNICITY & DISEASE 207 (1992).

15. It is hardly obvious that efforts to assert, in political debate, the competing importance of social and economic

determinants of health and health care access would result in reallocation of available resources from activities targeting racial disparities in clinical judgment to programs targeting social and economic inequality. Such an advocacy strategy might backfire, resulting in diminished efforts against racial bias in medical decisionmaking without a corresponding increase in efforts to ameliorate socio-economic inequities and their health effects.

16. John E. Wennberg, *Understanding Geographical Variations in Health Care Delivery*, 340 *NEW ENG. J. MED.* 52 (1999).

17. M. Gregg Bloche, *Medical Care and the Enigma of Efficiency* (2000) (unpublished manuscript, on file with author), available at http://papers.ssrn.com/paper.taf?abstract_id=184275 (last visited Apr. 24, 2001).

18. See GUIDO CALABRESI & PHILIP BOBBITT, *TRAGIC CHOICES* 57 (1978) (characterizing this approach as decisionmaking by "aresponsible" agencies and noting its effectiveness at concealing compromises between values we hold dear).

19. To be sure, medical malpractice lawyers often advise physicians to write progress notes giving reasons for clinical decisions so as to facilitate defense against potential tort claims. But these notes, in confidential patient records, do not create a public register of successive, related decisions.

20. ALVAN R. FEINSTEIN, *CLINICAL JUDGMENT* 328-49 (1967).

21. The probabilities derived from such an aggregation of prior outcomes

make possible predictive judgments about a current patient (so long as he or she meets the inclusion criteria) despite our ignorance about which features from prior cases are relevant to the clinical issue at hand.

22. Milliman & Robertson Inc., a Seattle-based consulting firm, developed a set of guidelines that were adopted by major health plans. Allen R. Myerson, *Helping Health Insurers Say No*, *N.Y. TIMES*, Mar. 20, 1995, at D1.

23. Contractual designation of the practice protocols to be used for payment determinations (and even incorporation of such protocols into insurance contracts) can resolve, in a formalistic manner, the question of which protocols apply, but it cannot resolve skepticism about the scientific legitimacy of the contractually mandated protocol.

24. HERBERT A. SIMON, *MODELS OF BOUNDED RATIONALITY* (1982).

25. Indeed, medical students and residents are taught to present cases, in work rounds and conferences, in a manner that conveys the presenter's hierarchy of diagnostic suspicions and makes the case for the diagnostic and therapeutic interventions the presenter proceeds to recommend. See generally JEFF GUSKY, *MEDICAL STUDENT'S WARD SURVIVAL MANUAL* 71-85 (1st ed. 1982).

26. The Oath states, in relevant part: "In every house where I come I will enter only for the good of my patients." *STEDMAN'S MEDICAL DICTIONARY* 799 (26th ed. 1995).

27. M. Gregg Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, 281 *JAMA*

268 (1999).

28. Daniel Sulmasy et al., *Physicians' Ethical Beliefs about Cost-Control Arrangements*, 160 ARCHIVES INTERNAL MED. 649, 651-52 (2000).

29. Another parallel is to the feminist ethic of care, which also eschews rule-oriented rationalism in favor of good motives (though it construes goodness somewhat differently, in terms of empathy and compassion). See Marilyn Friedman, *The Social Self and the Partiality Debates*, in FEMINIST ETHICS 161 (C. Card ed., 1991).

30. See Robert Cooter & Bradley J. Freedman, *The Fiduciary Relationship: Its Economic Character and Legal Consequences*, 66 N.Y.U. L. REV. 1045, 1053-1056 (1991).

31. See generally Jay Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137 (1977) (arguing that the law of informed consent does little to open the way for meaningful patient autonomy).

32. Even in "reasonable patient" jurisdictions, see, e.g., *Cobbs v. Grant*, 502 P.2d 1, 11 (Cal. 1972), treating physicians' practice styles determine the clinical options that patients are told about in fact. In the rare case when a patient brings suit on informed consent grounds, other physicians accessed by the patient-turned-plaintiff typically are the source of information about clinical options (and risks and benefits) not originally disclosed. Thus disclosure, in action, is largely a function of the physicians and clinical practice styles a patient encounters. For computer literate (and generally well-off) patients, the internet is emerging as an alternative, state-of-the-art source of information about clinical options. See

generally SCI. PANEL ON INTERACTIVE COMMUNICATION & HEALTH, WIRED FOR HEALTH AND WELL-BEING: THE EMERGENCE OF INTERACTIVE HEALTH COMMUNICATION (Thomas R. Eng & David H. Gustafson eds., 1999). This new source of medical information inequality further strains the formal equality expressed in informed consent doctrine.

33. *Black-White Disparities*, supra note 8.

34. See generally Susan T. Fiske, *Stereotyping, Prejudice, and Discrimination*, in 2 THE HANDBOOK OF SOCIAL PSYCHOLOGY 357, 377 (Daniel T. Gilbert et al. eds., 4th ed. 1998).

35. Within the psychodynamic paradigm, racial and other group stereotypes satisfy a person's needs for self-esteem and redirect his negative feelings about himself onto others. The sociocultural paradigm treats these stereotypes as social learning passed to people within a culture (and useful for rationalizing differential treatment of social groups). John F. Dovidio, *Stereotyping*, in THE MIT ENCYCLOPEDIA OF THE COGNITIVE SCIENCES 804 (Robert A. Wilson & Frank C. Keil eds., 1999).

36. Cindy Brach & Irene Fraser, *Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model*, 57 MED. CARE RES. & REV. 181-217 (2000); see also U.S. COMM'N ON CIVIL RIGHTS, 1 THE HEALTH CARE CHALLENGE: ACKNOWLEDGING THE DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY 193 (1999); Lisa Cooper-Patrick et al., *Race, Gender, and Partnership in the Patient-Physician Relationship*, 282 JAMA 583 (1999).

37. A substantial literature addresses, criticizes, defends, and attempts to explain the punishing time pressures, sleeplessness, and other stresses of clinical training. See generally John M. Colford, Jr. & Stephen J. McPhee, *The Ravelled Sleeve of Care: Managing the Stresses of Residency Training*, 261 JAMA 889-93 (1989); Jenny Firth, *Levels and Sources of Stress in Medical Students*, 292 BRIT. MED. J. 1177-80 (1986); Mitchel L. Zoler, *Residency Reform Spreads as Programs Combat Stress*, 29 MED. WORLD NEWS 49-50 (1988).
38. John Z. Ayanian et al., *The Effect of Patients' Preferences on Racial Differences in Access to Renal Transplantation*, 341 NEW ENG. J. MED. 1661-69 (1999).
39. For several decades after the advent of curative antibiotic therapy for syphilis, African-American patients with this illness were left untreated by researchers who wanted to observe the devastating, long-term neurological and other effects of syphilis. Allan Brandt, *Racism and Research: The Tuskegee Syphilis Experiment*, in TUSKEGEE TRUTH'S: RETHINKING THE TUSKEGEE SYPHILIS STUDY (Susan M. Reverby ed., 2000).
40. Patricia A. King, *Race, Justice, and Research*, in BEYOND CONSENT: SEEKING JUSTICE IN RESEARCH 88 (Jeffrey P. Kahn et al. eds., 1998).
41. Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191 (1996) (arguing that deep-rooted African-American fear and distrust of the health care system prevents many African Americans from seeking treatment).
42. *Pegram v. Herdrich*, 530 U.S. 211, 221 (2000).
43. James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1465-66 (1994).
44. Henry Hansmann, *The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation*, 91 YALE L.J. 54, 72-75 (1981).
45. Paul L. Joskow, *Certificate-of-Need Regulation*, in CONTROLLING HOSPITAL COSTS: THE ROLE OF GOVERNMENT REGULATION 76 (1981).
46. *Id.*
47. Jeffrey E. Harris, *Pricing Rules for Hospitals*, 10 BELL J. ECON. 224-43 (1979) (discussing internal organization and allocation within hospitals).
48. Such clinicians might include interns and residents, junior attending physicians, and more senior physicians with less prestigious credentials and appointments.
49. RAYMOND S. DUFF & AUGUST B. HOLLINGSHEAD, *SICKNESS AND SOCIETY* (1968).
50. *Id.* at 234.
51. *Id.*
52. Helen R. Burstin et al., *Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status*, 270 JAMA 1697 (1993).
53. Cognitive dissonance might well render this change in clinical ordering behavior unconscious, making it impossible to assay this effect by surveying physicians potentially involved.

54. This feature of medical tort law has been sharply criticized in recent years by market-oriented scholars who would prefer to see the courts recognize multiple tiers of clinical obligation, derived from contractual arrangements between health care payers, providers, and patients. *See, e.g.,* MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS 213-15 (1997); E. Haavi Morreim, *Playing Doctor: Corporate Medical Practice and Medical Malpractice*, 32 U. MICH. J. L. REF. 939 (1999).

55. PAUL C. WEILER, A MEASURE OF MALPRACTICE 69-70 (1993) (summarizing Harvard/New York State medical malpractice study data).

56. Burstin et al., *supra* note 52.

57. *E.g.,* Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J.L. & MED. 191 (1995).

58. Patients without private doctors who hold hospital staff privileges face a Catch-22 when they need hospital admission: since their outpatient clinic doctors cannot care for them as inpatients, they must either find private physicians with hospital privileges (difficult due to Medicaid's low payment rates) or be admitted as "ward" or "service" patients, cared for primarily by resident physicians.

59. 42 U.S.C.A. § 1396a(a)(13)(C) (1982 & Supp. V 1987), repealed by Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4712(c), 111 Stat. 509 (1997). A State plan for medical assistance must "provide...for payment...of hospital services, nursing facility services, and

services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State...) which the State funds, and makes assurances satisfactory to the [Health and Human Services] Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access...to inpatient hospital services of adequate quality."

60. *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990) (holding that the Boren Amendment created substantive federal right enforceable by health care providers).

61. The causal connections between administrative fragmentation, racial segregation, and inequality in social programs have been explored by commentators in other policy contexts, especially housing. *See, e.g.,* Philip D. Tegeler, *Housing Segregation and Local Discretion*, 3 J.L. & POL'Y 209, 234-35 (1994). *See also* COMM. ON IMPROVING THE FUTURE OF U.S. CITIES THROUGH IMPROVED METRO. AREA GOVERNANCE, NAT'L RESEARCH COUNCIL, GOVERNANCE AND OPPORTUNITY IN METROPOLITAN AMERICA (Alan Altshuler et al. eds., 1999). The connection, by design, between unusual bureaucratic fragmentation and shocking inequalities in health care provision was dramatically evident in the South African health care system under apartheid. AM. ASS'N FOR THE

ADVANCEMENT OF SCI. & PHYSICIANS FOR HUMAN RIGHTS, HUMAN RIGHTS & HEALTH: THE LEGACY OF APARTHEID (Audrey R. Chapman & Leonard S. Rubenstein eds., 1998) [hereinafter THE LEGACY OF APARTHEID].

62. *Supra* text accompanying notes 100-104.

63. EMTALA, 42 U.S.C. § 1395dd (1995).

64. EMTALA, which requires all of this regardless of emergency room patients' ability or willingness to pay, has been sharply (and, I think, reasonably) criticized as yet another unfunded federal mandate, and thus a hidden government levy on those who cross-subsidize the mandate's cost. *See, e.g.*, David Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29, 53 (1998).

65. *See, e.g.*, *Summers v. Baptist Med. Ctr. Arkadelphia*, 69 F.3d 902, 904 (8th Cir. 1995) ("EMTALA is not a federal malpractice statute and it does not set a national emergency health care standard; claims of misdiagnosis or inadequate treatment are left to [state law]"); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995) (holding that EMTALA creates no national standard of emergency care); *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872 (8th Cir. 1992) (holding that EMTALA does not create a national medical malpractice standard and that EMTALA liability for emergency medical screening comes only if the facility fails to comply with its own procedures).

66. EMTALA confers a private cause of action against hospitals (but not physicians) upon patients who are

discharged or transferred without an adequate emergency screening evaluation or stabilizing treatment. *See* EMTALA, *supra* note 63, at §1395dd(d)(2)(A).

67. RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 60-61 (1997).

68. The Department of Health, Education, and Welfare.

69. Some hospitals pursued the facially neutral strategy of refusing to grant privileges to physicians who were not members of their local medical societies. The catch, for African-American doctors (and their patients) in some localities, was that these medical societies (which received no "federal financial assistance" and were thus beyond Title VI's reach) refused admission to blacks. DAVID B. SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 16-21 (1999).

70. *E.g., id.* at 200-25.

71. Sara Rosenbaum et al., *U.S. Civil Rights Policy and Access to Health Care by Minority Americans: Implications for a Changing Health Care System*, 57 MED. CARE RES. & REV. 236, 247 (Supp. I 2000).

72. *Id.* at 238; *see also*, U.S. COMM'N ON CIVIL RIGHTS, *supra* note 36, at 77 (asserting deficiencies in Title VI regulations).

73. The 1988 Amendment of 29 U.S.C. § 794, Nondiscrimination under Federal Grants and Programs, added subsection b, which defined "program or activity" as "the operations of...an entire corporation, partnership, or other private organization, or an entire sole proprietorship—(i) if assistance is extended to such corporation, partnership, private organization, or sole proprietorship as a whole or (ii) which is

principally engaged in the business of health care.” 29 U.S.C. § 794(b)(3)(A).

74. Rosenbaum et al., *supra* note 71, at 239.

75. Over thirty-nine million Americans are enrolled in Medicare today. See Statistics on Medicare Enrollment Trends of the Health Care and Financing Administration: 1966-1999, at <http://www.hcfa.gov/stats/enrltrnd.htm#t1> (last visited Apr. 24, 2001).

76. U.S. COMM’N ON CIVIL RIGHTS, *supra* note 36; Rosenbaum et al., *supra* note 71.

77. Mark Barnes & Elizabeth Weiner, *Evidence of Race-Based Discrimination Triggers New Legal and Ethical Scrutiny*, 8 BNA HEALTH L. RPTER. 1984 (1999) (suggesting that statistical evidence of racial disparity in the treatment of patients may serve as the basis for charges of race and/or ethnicity-based discrimination).

78. *Id.*

79. *Alexander v. Sandoval*, 69 U.S.L.W. 4250 (2001).

80. See *King*, *supra* note 40.

81. See *Bloche*, *supra* note 27.

82. *Washington v. Harper*, 494 U.S. 210, 243-45 (1990) (Stevens, J., dissenting) (challenging a prison policy that authorized treatment of a mentally ill state prisoner with antipsychotic drugs against his will without judicial hearing).

83. William Booth, *U.S. Accused of Sedating Deportees; Tranquilizers Given to Those Who Resist*, WASH. POST, Oct. 7, 1993, at A1.

84. M. Gregg Bloche, *A Step Ahead of the Law*, in *THE PRIVATIZATION OF HEALTH CARE REFORM* (M. Gregg Bloche ed., forthcoming).

85. *Supra* text accompanying notes 22-25.

86. *Supra* text accompanying notes 48-51.

87. Discovery in the pending HMO class action litigation could shed some light on whether these factors play a role, as plaintiffs’ attorneys obtain health plans’ internal memoranda, e-mail, and other communications concerning utilization management policy.

88. See generally, Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts*, 35 HOUS. L. REV. 985 (1998) (arguing that the formalistic ERISA preemption analysis applied by courts allowed managed care organizations to escape liability for their negligence when providing health care and health care financing).

89. *E.g.*, *Corcoran v. United HealthCare*, 965 F.2d 1321 (5th Cir. 1992) (holding that ERISA preempted Louisiana tort action for wrongful death of unborn child).

90. Under ERISA, these decisions held that a plaintiff alleging improper denial of benefits could recover only the dollar value of the treatment denied—e.g. the \$300 dollar cost of a CT scan inappropriately withheld, and not for other resulting damages—e.g. wrongful death if the CT scan would have revealed the plaintiff’s fatal (but treatable) illness.

91. *Compare Corp. Health Ins., Inc. v. Tex. Dep’t of Ins.*, 215 F.3d 526 (5th Cir. 2000) (concluding that ERISA preempts the provisions of a Texas statute that establishes a system of appellate review of HMO benefits decisions), *with Moran v.*

Rush Prudential HMO, 230 F.3d 959 (7th Cir. 2000) (holding that ERISA does not preempt an Illinois statute that requires HMOs to submit claim denials for review by an independent physician).

92. Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy*, 320 NEW. ENG. J. MED. 29 (1989).

93. JAMES C. ROBINSON, *THE CORPORATE PRACTICE OF MEDICINE: COMPETITION AND INNOVATION IN HEALTH CARE* 63-89 (1999). Forces driving this market trend included consumers' desire for more choice from among providers and plan designs than vertically integrated health plans could offer and industry executives' anticipation of possible regulatory and legal developments that would subject vertically integrated plans to heightened liability risk and public oversight. Bloche, *supra* note 27.

94. *Id.*

95. Thomas Rice, *Physician Payment Policies: Impacts and Implications*, 18 ANN. REV. PUB. HEALTH 549 (1997).

96. Examples include rewards to pediatricians for retention of patients in well child care, and rewards to internists, gynecologists, and urologists whose patients are screened appropriately for colon, breast, and prostate cancer.

97. Examples include rewards for keeping patients with chronic, treatable but relapsing illnesses such as asthma and schizophrenia out of the hospital.

98. *Pegram*, 530 U.S. at 221.

99. M. Gregg Bloche & Peter D. Jacobson, *The Supreme Court and Bedside*

Rationing, 284 JAMA 2776 (2000).

100. See HALL, *supra* note 54.

101. A confounding problem in such research is the fact that measures of health status are highly correlated with indices of socio-economic status, making it difficult to draw conclusions about causality from correlations between low-end coverage (hard in itself to define operationally in view of the many features of medical coverage) and either health outcomes or levels of intensity of care.

102. THE LEGACY OF APARTHEID, *supra* note 61, at 18-24.

103. ROBINSON, *supra* note 93, at 35-62.

104. M. Gregg Bloche & Kevin Quinn, *Professionalism and Personhood*, in PERSONHOOD IN HEALTH CARE (David Thomas ed., forthcoming).

105. Peter D. Jacobson & Michael T. Cahill, *Applying Fiduciary Responsibilities in the Managed Care Context*, 26 AM. J.L. & MED. 155 (2000).

106. The complex question of how to fashion such limits is beyond my scope here. It is one of the most important challenges for health care law, and it has received insufficient attention from scholars and policymakers thus far.

107. Bloche & Jacobson, *supra* note 99, at 2777.

108. Potential measures of stability include mean frequency of changes in patients' assignments to primary care physicians, percentages of patients who change primary caretakers at rates that exceed "red flag" thresholds, and rates at which hospitalized patients are attended by their outpatient primary physicians.

109. Potential measures of accessibility

include waiting times for routine and urgent care appointments and frequencies at which patients are seen by physicians other than their primary care providers.

110. Somnath Saha et al., *Patient-Physician Racial Concordance and the Perceived Quality and Use of Health Care*, 159 ARCHIVES INTERNAL MED. 997 (1999).

111. *Supra* text accompanying notes 101-103.

