

## Patients' Racial Preferences and the Medical Culture of Accommodation

Kimani Paul-Emile



### ABSTRACT

One of medicine's open secrets is that patients routinely refuse or demand medical treatment based on the assigned physician's racial identity, and hospitals typically yield to patients' racial preferences. This widely practiced, if rarely acknowledged, phenomenon—about which there is new empirical evidence—poses a fundamental dilemma for law, medicine, and ethics. It also raises difficult questions about how we should think about race, health, and individual autonomy in this context. Informed consent rules and common law battery dictate that a competent patient has an almost-unqualified right to refuse medical care, including treatment provided by an unwanted physician. Yet the accommodation of patients' racial preferences with respect to their choice of physician in the hospital context appears to violate antidiscrimination principles. How should we reconcile this apparent conflict between respect for patient autonomy and accepted notions of racial equality? Moreover, is the accommodation of patients' racial preferences the type of invidious discrimination that civil rights laws were enacted to prevent?

This Article engages these questions through an evaluation of antidiscrimination norms, principles of medical ethics, and federal laws, including Titles II, VI, and VII of the Civil Rights Act. In so doing, the Article offers critical insights into why a form of discrimination that is prohibited in other contexts is tolerated in the hospital setting and draws important conclusions about the legal propriety and medical efficacy of this practice. The Article contends that the various titles of the Civil Rights Act offer no clear legal directive on this practice, and it makes the counterintuitive claim that although hospital accommodation of patients' racial preferences appears to contravene antidiscrimination principles, it is not only consistent with our normative commitments to racial equality but, in fact, constitutes an effective means of alleviating race-based health disparities, improving health outcomes, and quite possibly, saving patients' lives.

### AUTHOR

Kimani Paul-Emile is Associate Professor of Law at Fordham University School of Law.

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## INTRODUCTION

In early November 1931, Juliette Derricotte, Dean of Women at Hampton and Fisk College and former executive of the national YWCA, sustained severe injuries during a car accident. The closest hospital advertised “no Negroes,” so an ambulance was summoned from sixty-six miles away to take her to a hospital that treated black patients. She died of her injuries before she could receive treatment.<sup>1</sup> Similarly, in 1940, John McBride was denied admission at two local south Florida hospitals after suffering a bullet wound.<sup>2</sup> The only two hospitals in the area that accepted black patients were miles away in Miami and West Palm Beach; thus McBride died without hospital care.

These tragic accounts are stark reminders of a history that many Americans believe is long past. Yet, race discrimination in the provision of healthcare is not a relic of the Jim Crow era. Discrimination still occurs quite frequently, and healthcare providers actively and routinely facilitate it. This modern-day race discrimination assumes a form distinct from the type that led to the deaths of Juliette Derricotte, John McBride, and countless others, and it is in many ways more complex, nuanced, and perplexing. When we think of race discrimination in healthcare today, we tend to think about race-based health disparities and bias exhibited by physicians or other providers, but new studies illuminate a different kind of race discrimination in the hospital setting. Today, rather than turning patients away based on race, healthcare providers are instead facilitating patients’ racial biases by enabling them to turn physicians away based on race. In other words, healthcare providers accommodate patients’ racial preferences.<sup>3</sup>

Consider two examples: An older patient of Korean ancestry enters the hospital in very poor health with a condition that is difficult both to diagnose and to

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1. See W. MICHAEL BYRD & LINDA A. CLAYTON, AN AMERICAN HEALTH DILEMMA: RACE, MEDICINE AND HEALTH CARE IN THE UNITED STATES 1900–2000, at 181 (2002).
  2. See DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 19 (1999).
  3. See generally Aasim I. Padela et al., *Patient Choice of Provider Type in the Emergency Department: Perceptions and Factors Relating to Accommodation of Requests for Care Providers*, 27 EMERGENCY MED. J. 465 (2010); Emilia Benton, *Should EPs Accommodate Patient Requests for a Specific Doctor? Many Do*, EMERGENCY MED. NEWS, Apr. 2011, at 22, available at [http://journals.lww.com/em-news/Fulltext/2011/04000/Breaking\\_News\\_\\_Should\\_EPs\\_Accommodate\\_Patient.3.aspx](http://journals.lww.com/em-news/Fulltext/2011/04000/Breaking_News__Should_EPs_Accommodate_Patient.3.aspx); Vida Foubister, *Requests by Patients Can Put Doctors in Ethical Bind*, AM. MED. NEWS (Jan. 22, 2001), <http://www.ama-assn.org/amednews/2001/01/22/prsb0122.htm>; Kenneth Kipnis, *Quality Care and the Wounds of Diversity*, 97 APA NEWSLS. 112, 112–13 (1998); *Women, Minorities More Likely to See Doctor of Choice in Emergency Room*, U. MICH. HEALTH SYS. (July 22, 2010), <http://www2.med.umich.edu/prmc/media/newsroom/details.cfm?ID=1664>.

treat. He is offered a treatment regimen that promises a better than 50 percent chance of recovery with minimal risks, yet he nevertheless refuses further medical intervention. The hospital thus stops all treatment and the patient would likely have died had a member of the hospital medical staff not noticed that the patient had also requested full cardiopulmonary support should he go into arrest. When confronted with this seeming contradiction, the patient confesses that he does not want to be treated by the assigned physicians, who were of Japanese descent. The physicians accede to the patient's wishes, he accepts treatment, and he makes a full recovery.<sup>4</sup>

A patient with a potentially life-threatening cardiovascular disorder is taken to the hospital for surgery. Prior to the procedure, the patient's husband demands that the hospital prohibit black men from entering the operating room during the surgery. The surgeon accommodates the patient's request and later explains that he did so because he did not believe that the patient would have otherwise gone through with the surgery.<sup>5</sup> Both examples are real-life accounts of healthcare providers yielding to patients' racially biased demands. Such requests by patients are not only quite common but also are often accommodated quietly.<sup>6</sup>

A recent study shows that some patients refuse or demand treatment based on the racial identity of the assigned healthcare provider and that providers are likely to accede to these patients' preferences.<sup>7</sup> Research also reveals that patients of all races make race-based choices about who may treat them in hospitals. Many healthcare providers accommodate these requests in circumstances in which the patient has no option for care other than a hospital outpatient department and in situations in which a patient is in need of emergency services.<sup>8</sup> Indeed, according to Herbert Rakatansky, MD, former Chair of the American Medical Association's (AMA) Council on Ethical and Judicial Affairs, "In a life-threatening situation, you would have to abide by the patient's request."<sup>9</sup>

The culture of accommodation in the hospital setting has created a clash of competing medical ethics and legal norms: evidence-based and patient-centered approaches to medical care versus accepted notions of racial equality and antidis-

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4. Kipnis, *supra* note 3, at 112–13.

5. Foubister, *supra* note 3.

6. See Chaney v. Plainfield Healthcare Ctr., 612 F.3d 908, 912 (7th Cir. 2010) (addressing patient preference discrimination in long-term healthcare facilities); Foubister, *supra* note 3; *Women, Minorities More Likely to See Doctor of Choice in Emergency Room*, *supra* note 3.

7. Padelá et al., *supra* note 3, at 465; see also Foubister, *supra* note 3.

8. This observation is based on data obtained through author interviews with physicians from September 2011 through July 2012.

9. Foubister, *supra* note 3.

crimination principles.<sup>10</sup> Medical ethics, for example, embraces patient-oriented strategies for the provision of care, including the dictates of the Hippocratic Oath, as well as informed-consent rules and common law battery, which make clear that competent patients have a right to refuse unwanted medical treatment.<sup>11</sup> Yet, while the AMA's Code of Medical Ethics maintains that physicians "may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination," the medical profession does not have a specific policy regarding healthcare institutions accommodating patients' racially biased requests.<sup>12</sup>

Likewise, the law offers little guidance on how to address this practice. Although several titles of the 1964 Civil Rights Act (CRA) speak to similar types of discrimination—including Title VII, which prohibits employers from catering to the racially biased requests of their clientele—they do not offer a clear legal directive on the issue of hospitals acceding to the racial preferences of their patients.<sup>13</sup> The only case that comes close to approaching this issue is *Chaney v. Plainfield Healthcare Center*,<sup>14</sup> in which the Seventh Circuit Court of Appeals held that Title VII bars nursing homes from acceding to their residents' racially discriminatory requests with respect to certified nursing assistants. But, for reasons explained in Part III, this case does not meaningfully attend to the matter of hospitals facilitating patients' racial preferences regarding their choice of physician.

This widespread phenomenon raises difficult questions about how we should think about race, health, and individual autonomy in this context. Should we, for example, think the same way about all the types of preferences expressed? Does the fact that some racial preferences evoke the types of discrimination long outlawed by civil rights statutes render patient racial accommodations problematic? Are there reasons to treat the different examples differently? Questions such as these pose a fundamental dilemma for law, medicine, and ethics. This Article is the first to address these questions and bring into the legal literature an examination of the medical practice of race-based patient accommodation.

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10. *Women, Minorities More Likely to See Doctor of Choice in Emergency Room*, *supra* note 3.

11. *See infra* Part II.

12. *See* AMA Code of Medical Ethics, Opinion 9.12—Physician–Patient Relationship: Respect for Law and Human Rights (2008), *available at* <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion912.page>.

13. Civil Rights Act of 1964, 42 U.S.C. §§ 2000a, 2000e (2006). The various titles of the CRA proscribe unequal application of voter registration requirements and racial segregation in education, employment, and public accommodations. *See id.*

14. 612 F.3d 908 (7th Cir. 2010).

At first blush, antidiscrimination law and general racial-equality principles would seem to bar hospitals from accommodating patients' racial preferences despite the quiet persistence of this practice. This Article makes the counterintuitive claim, however, that the law does and should permit this practice, and that accommodating patients' racial preferences actually advances racial equality. It demonstrates that there are, in fact, many good reasons to allow hospitals to accommodate patients' racial preferences. Recent empirical data on physician-patient race concordance (the ability of a patient to be treated by a healthcare practitioner of the same racial background, ethnic background, or both) show that permitting hospitals to accede to their patients' racial preferences may not only alleviate race-based health disparities but also constitute a life-saving measure for many racial-minority patients.<sup>15</sup> I contend, therefore, that in the absence of countervailing law or of evidence that accommodating expressions of racial preferences would compromise care, and in light of the significant health benefits conferred by this practice, the accommodation of patients' racial preferences with respect to their choice of physician should be preserved in the hospital setting.

Legal scholars have long debated ways to deal with race in several contexts, particularly in the realms of criminal justice,<sup>16</sup> housing,<sup>17</sup> and edu-

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15. See *infra* Part IV.

16. See generally BENJAMIN BOWLING & CORETTA PHILLIPS, *RACISM, CRIME AND JUSTICE* (2002); DAVID GARLAND, *PECULIAR INSTITUTION: AMERICA'S DEATH PENALTY IN AN AGE OF ABOLITION* (2010); RANDALL KENNEDY, *RACE, CRIME, AND THE LAW* (1997); RACE, ETHNICITY, SEXUAL ORIENTATION, VIOLENT CRIME: THE REALITIES AND THE MYTHS (Nathaniel J. Pallone ed., 2000); SAMUEL WALKER ET AL., *THE COLOR OF JUSTICE: RACE, ETHNICITY, AND CRIME IN AMERICA* (2d ed. 2000); Angela J. Davis, *Benign Neglect of Racism in the Criminal Justice System*, 94 MICH. L. REV. 1660 (1996); Sheri Lynn Johnson, *Unconscious Racism and the Criminal Law*, 73 CORNELL L. REV. 1016 (1988); Dorothy E. Roberts, *Foreword: Race, Vagueness, and the Social Meaning of Order-Maintenance Policing*, 89 J. CRIM. L. & CRIMINOLOGY 775 (1999).

17. See generally Michelle Adams, *Is Integration a Discriminatory Purpose?*, 96 IOWA L. REV. 837 (2011) (discussing recent Supreme Court doctrine that may prohibit governments from racially integrating different sectors, including the housing sector, unless they do so through facially neutral programs); Margalynne Armstrong, *Protecting Privilege: Race, Residence and Rodney King*, 12 LAW & INEQ. 351 (1994) (arguing that racial and economic residential segregation inhibit the social mobility of the poor); Isaac N. Groner & David M. Helfeld, *Race Discrimination in Housing*, 57 YALE L.J. 426 (1948) (discussing racial segregation in housing patterns by public and private authorities); Rigel C. Oliveri, *Is Acquisition Everything? Protecting the Rights of Occupants Under the Fair Housing Act*, 43 HARV. C.R.-C.L. L. REV. 1 (2008) (discussing a recent trend of courts interpreting the Fair Housing Act not to protect occupants from discrimination after they have moved into their homes); Florence Wagman Roisman, *Intentional Racial Discrimination and Segregation by the Federal Government as a Principal Cause of Concentrated Poverty: A Response to Schill and Wachter*, 143 U. PA. L. REV. 1351 (1995) (discussing racial discrimination and segregation by federal housing programs); Adam Weiss, Grutter, Community, and Democracy: *The Case for Race-Conscious Remedies in Residential Segregation Suits*, 107 COLUM. L. REV. 1195 (2007) (arguing that the Equal Protection Clause allows judges to set remedial goals for residential integration that take account of individuals' races).

cation.<sup>18</sup> Relatively little attention, however, has been paid to the ways in which race is deployed in healthcare. This is particularly worrisome because issues of race can affect both patient care and health outcomes. And to the extent that these issues are considered, the focus has been on race-based health disparities and on bias by physicians and other healthcare providers.<sup>19</sup> Yet there has been no analysis in the legal literature of the propriety of healthcare institutions acceding to individual patients' racial prejudices.

Scholars in other fields, primarily medicine and public health, have attempted to examine this phenomenon empirically by assessing its prevalence,<sup>20</sup> the contexts

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18. See generally Ian Ayres & Sydney Foster, *Don't Tell, Don't Ask: Narrow Tailoring After Grutter and Gratz*, 85 TEX. L. REV. 517 (2007); Kevin Brown & Jeannine Bell, *Demise of the Talented Tenth: Affirmative Action and the Increasing Underrepresentation of Ascendant Blacks at Selective Higher Educational Institutions*, 69 OHIO ST. L.J. 1229 (2008); Harry T. Edwards, *The Journey From Brown v. Board of Education to Grutter v. Bollinger: From Racial Assimilation to Diversity*, 102 MICH. L. REV. 944 (2004); Rachel F. Moran, *Diversity and Its Discontents: The End of Affirmative Action at Boalt Hall*, 88 CALIF. L. REV. 2241 (2000); Angela Onwuachi-Willig, *The Admission of Legacy Blacks*, 60 VAND. L. REV. 1141 (2007).
  19. See Dayna Bowen Matthew, *A New Strategy to Combat Racial Inequality in American Health Care Delivery*, 9 DEPAUL J. HEALTH CARE L. 793, 796, 798–821 (2005) (discussing how, despite its success in desegregating hospitals, Title VI has largely been ineffective in preventing race-based discrimination with respect to quality of care); Brietta R. Clark, *Hospital Flight From Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023, 1028–44, 1056–88 (2005) (discussing how hospital closures in poor minority communities demonstrate persistent racial discrimination in healthcare and how the current legal structure has not prevented such discrimination); Lisa C. Ikemoto, *In the Shadow of Race: Women of Color in Health Disparities Policy*, 39 U.C. DAVIS L. REV. 1023, 1046–52 (2006) (discussing how the current analysis of racial disparities in healthcare fails to take into account gender disparities as well, thus continuing a pattern of discrimination against women of color); Kevin Outterson, *The End of Reparations Talk: Reparations in an Obama World*, 57 U. KAN. L. REV. 935, 946–48 (2009) (discussing how President Obama's focus on health reform, and not on reparations, might be successful in reducing racial disparities in access to healthcare); Vernellia R. Randall, *Eliminating Racial Discrimination in Health Care: A Call for State Health Care Anti-discrimination Law*, 10 DEPAUL J. HEALTH CARE L. 1, 8–24 (2006) (discussing how Title VI has not prevented racial discrimination because the Supreme Court has ruled that it only prohibits intentional discrimination); Ruqaiyah Yearby, *Does Twenty-Five Years Make a Difference in "Unequal Treatment"? The Persistence of Racial Disparities in Health Care Then and Now*, 19 ANNALS HEALTH L. 57, 57 (2010) (discussing how current federal programs aimed at eliminating racial discrimination in healthcare have been unsuccessful and calling "scholars, researchers, and federal officials to adopt a new approach to eradicate racial disparities").
  20. See generally Lisa A. Cooper et al., *Patient-Centered Communication, Ratings of Care, and Concordance of Patient and Physician Race*, 139 ANNALS INTERNAL MED. 907 (2003); Thomas A. LaVeist et al., *The Association of Doctor-Patient Race Concordance With Health Services Utilization*, 24 J. PUB. HEALTH POL'Y 312 (2003); Jennifer Malat & Mary Ann Hamilton, *Preference for Same-Race Health Care Providers and Perceptions of Interpersonal Discrimination in Health Care*, 47 J. HEALTH & SOC. BEHAV. 173 (2006); Irena Stepanikova et al., *Patients' Race, Ethnicity, Language, and Trust in a Physician*, 47 J. HEALTH & SOC. BEHAV. 390 (2006); Damon Adams, *Patients Say Best Doctors Are*

in which these preferences are exercised,<sup>21</sup> and the connection between patients' preferences and both healthcare utilization and health outcomes.<sup>22</sup> These scholars have tended to base their analyses in autonomy and informed consent, but this literature has not endeavored to address antidiscrimination law and norms.

This Article, therefore, attempts to advance our understanding of this phenomenon by evaluating federal laws, antidiscrimination norms, evidence-based medical practices, and medical ethics principles in order to draw important conclusions about the phenomenon's legal propriety and medical efficacy. In so doing, the Article offers critical insights into why a form of discrimination that is rightly prohibited in other contexts should be tolerated in the hospital setting.

The remainder of this Article proceeds as follows. Part I investigates the hospital practice of bowing to patients' race-based requests and the motivation behind physicians' willingness to do so. To this end, Part I examines the first major empirical study to address how physicians respond when they are asked to make compromises to meet patients' racial preferences.

Part II maps the prevailing medical ethics principles and legal doctrines that operate as default rules governing a patient's right to refuse unwanted medical treatment, including the doctrines of informed consent and common law battery. This Part also addresses the Emergency Medical Treatment and Active Labor Act (EMTALA),<sup>23</sup> which requires hospitals to provide a medical screening examination and medical treatment, if necessary, to any individual who comes to a hospital

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*Ones Who Look Like Them*, AMEDNEWS.COM (Jan. 12, 2004), <http://www.ama-assn.org/amednews/2004/01/12/prse0112.htm>.

21. See generally Padela et al., *supra* note 3 (analyzing how doctors respond to patients' preferences for emergency medical providers of similar backgrounds); Frederick M. Chen et al., *Patients' Beliefs About Racism, Preferences for Physician Race, and Satisfaction With Care*, 3 ANNALS FAM. MED. 138 (2005) (analyzing surveys showing that minorities who perceive racism in the healthcare system are more likely to prefer physicians of the same race); Somnath Saha et al., *Do Patients Choose Physicians of Their Own Race?*, 19 HEALTH AFF. 76 (2000) (arguing that minority patients' preferences for physicians of their own race should encourage medical schools to reassess their admissions policies to increase the supply of minority physicians).
22. See generally UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley et al. eds., 2003) (analyzing why racial and ethnic minorities tend to receive healthcare of a lower quality); Chen et al., *supra* note 21; Adil H. Haider et al., *Association of Unconscious Race and Social Class Bias With Vignette-Based Clinical Assessments by Medical Students*, 306 J. AM. MED. ASS'N 942 (2011) (analyzing unconscious race and social-class bias among medical students); Thomas A. LaVeist & Amani Nuru-Jeter, *Is Doctor-Patient Race Concordance Associated With Greater Satisfaction With Care?*, 43 J. HEALTH & SOC. BEHAV. 296 (2002); Salimah H. Meghani et al., *Patient-Provider Race-Concordance: Does It Matter in Improving Minority Patients' Health Outcomes?*, 14 ETHNICITY & HEALTH 107 (2009).
23. Pub. L. No. 99-272, § 9121(b), 100 Stat. 82, 164-67 (1986) (codified as amended at 42 U.S.C. § 1395dd (2006)).



emergency department requesting treatment for an emergency medical condition.<sup>24</sup> Part II, thus, lays the groundwork in medical ethics for considering the legality and propriety of allowing healthcare providers to submit to a patient's request for or refusal of treatment by a physician of a particular race.

Part III addresses the antidiscrimination laws that may speak to the accommodation of patients' racial preferences, including Title II, which prohibits commercial entities from catering to the racially biased requests of customers; Title VI, which prohibits race discrimination by any entity receiving federal funds; and Title VII, which precludes employers from acceding to the discriminatory preferences of their clientele.<sup>25</sup> This Part demonstrates, first, that there is no clear legal directive on the issue of hospitals accommodating patients' racial preferences. Second, building on an analysis of recent empirical data on physician-patient race concordance and medical best practices, Part III argues that this practice does not constitute the type of discrimination that these laws were enacted to address. In so doing, this Part demonstrates the ways in which bowing to patients' racial preferences actually constitutes an effective means of improving minority health outcomes, alleviating health disparities among racial groups, and addressing racial subordination in the physician-patient relationship.

The practice of hospitals accommodating patients' racial preferences, however, is not without its troubling aspects. Therefore, although Part IV argues that patients' race-based requests should be respected in the hospital context, it also acknowledges the difficulties attendant to indulging such requests, and it concludes by proposing policy solutions designed to alleviate the need to yield to patients' racial preferences over the long term.<sup>26</sup>

## I. PHYSICIANS AND THE ACCOMMODATION OF PATIENTS' PREFERENCES

In 2010, researchers at the University of Michigan Health System and colleagues at the University of Pennsylvania and the University of Rochester published an unprecedented study that received considerable attention within medical circles because it revealed one of medicine's open secrets: how physicians respond

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24. See Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(a).

25. Civil Rights Act of 1964, 42 U.S.C. §§ 2000a, 2000d, 2000e.

26. Although in the hospital context physicians also often accommodate patients' religious and gender preferences with respect to their choice of physicians, this Article focuses on the accommodation of patients' racial preferences.

to patient requests for providers of the same gender, race, or religion.<sup>27</sup> This first empirical study of the “culture of accommodation” in the hospital setting involved a survey of 127 emergency physicians from around the United States, and its results were unequivocal.<sup>28</sup>

According to the study, patients often request a physician of a race, gender, or religion different from the one assigned, and such demands are accommodated routinely.<sup>29</sup> Such requests are most frequently granted when the patient is a woman, a racial minority, or a Muslim; and black, Hispanic, and Asian patients tend to believe that they receive better care from doctors of the same race.<sup>30</sup> Female physicians are more likely to accede to reassignment requests,<sup>31</sup> and research shows that doctors at large and academically affiliated hospitals are more likely to accommodate these requests than those at community facilities.<sup>32</sup> Doctors have expressed that they feel a particular need to acquiesce to these requests in urgent situations and in circumstances in which a patient has few, if any, alternate venues for care other than the hospital setting.<sup>33</sup> The findings of the University of Michigan study and other documented accounts of healthcare providers accommodating patients' racial preferences support the author's own interviews with scores of physicians working in hospitals throughout the United States. This, coupled with the fact that demand for hospital emergency services has risen steadily since 1996, suggests that the accommodation of patients' racial biases may be a widespread phenomenon.<sup>34</sup>

Although physicians are frequently called on to decide whether to accommodate patients' preferences, hospitals lack policies to address this practice. According to Rick Wade, former senior vice president of the American Hospital Association, “Hospitals do a lot of things every day to meet the special requirements of patients. They do that as long as it does not compromise the hospital's ability to deliver good medical care and does not interfere with the operation of the institution. . . . Every patient has the choice of the physician who is in control of

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27. Padela et al., *supra* note 3; see also Benton, *supra* note 3; Foubister, *supra* note 3; *Women, Minorities More Likely to See Doctor of Choice in Emergency Room*, *supra* note 3.

28. Padela et al., *supra* note 3, at 468.

29. *Women, Minorities More Likely to See Doctor of Choice in Emergency Room*, *supra* note 3.

30. Padela et al., *supra* note 3, at 467–68.

31. *See id.* at 466.

32. *Id.* at 467 tbl.3.

33. Foubister, *supra* note 3. Given that, in nonemergency situations, patients may perform ex ante research to choose a physician who fits their desired characteristics, it likely follows that patient requests for race-concordant physicians will occur most often in the emergency setting.

34. See Eryn Brown, *CDC: Emergency Room Visits Surged in 2009*, L.A. TIMES, Oct. 18, 2011, <http://articles.latimes.com/2011/oct/18/news/la-heb-emergency-room-visits-up-20111018>.

their care, and it's up to that physician and the hospital then to assemble the team to do the job."<sup>35</sup>

Although patients have long enjoyed the freedom to select personal physicians, and have been able to base their decisions on the physician's race, gender, or ethnicity, in the hospital setting this practice raises unique concerns. Here, the danger does not lie in the patient's own sense of the relevance of race, nor is it simply a matter of the patient exercising private preferences. Rather, the concern is that by bringing their preferences into the hospital setting and demanding accommodations, these patients are confronting healthcare providers with a difficult conflict between their professional obligation to provide nondiscriminatory care and their ethical obligations to respect patients' decisionmaking autonomy and to advance patients' medical best interests.

In the following Parts, this Article charts a course for how we should think about the practice of accommodating patients' racial preferences both as a legal and as an ethical matter, beginning with a discussion of the significance of EMTALA, informed consent, and battery.

## II. THE DEFAULT RULES: INFORMED CONSENT, COMMON LAW BATTERY, AND EMTALA

Physicians operate in accordance with a code of medical ethics that emphasizes the interests of patients and the obligations of physicians. The basic principles that form the core of this code are nonmaleficence, respect for persons, beneficence, and justice.<sup>36</sup> The concept of nonmaleficence, derived from the Hippocratic Oath, reminds physicians to do no harm.<sup>37</sup> Respect for persons is an understanding that patients must be empowered to make informed and autonomous healthcare decisions.<sup>38</sup> Beneficence is the notion that healthcare providers' primary obligation is to confer benefits while balancing the risks attendant to the provision of healthcare.<sup>39</sup> Justice refers to the fair distribution of scarce resources and respect for individual rights.<sup>40</sup> These obligations form the normative backdrop for a physicians' duty to

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35. Foubister, *supra* note 3 (alteration in original) (internal quotation marks omitted).

36. See generally TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (5th ed. 2001); NAT'L COMM'N FOR THE PROT. OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, *THE BELMONT REPORT: ETHICAL PRINCIPLES AND GUIDELINES FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH* (1979), available at <http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html>.

37. See TERRY M. PERLIN, *CLINICAL MEDICAL ETHICS: CASES IN PRACTICE* 11 (1992).

38. BEAUCHAMP & CHILDRESS, *supra* note 36, at 57–112.

39. Raanan Gillon, *Medical Ethics: Four Principles Plus Attention to Scope*, 309 *BMJ* 184, 184–85 (1994).

40. BEAUCHAMP & CHILDRESS, *supra* note 36, at 226–27.

provide care, and they undergird the prevailing legal doctrines that govern the accommodation of patients' racial preferences in the hospital setting: informed consent, battery, and EMTALA.

Informed consent, which emerged from the law of battery, is the doctrinal antecedent of the right to refuse unwanted medical care. Indeed, the right of informed consent assumes a corollary right of informed refusal. Thus, a competent patient has a common law and constitutionally protected liberty interest in refusing unwanted medical care.<sup>41</sup> EMTALA, the federal anti-patient-dumping statute, requires hospitals to provide a medical screening examination to any individual who arrives in a hospital emergency department requesting medical treatment.<sup>42</sup>

This Part illustrates how these laws and legal doctrines operate as guidelines that inform the way physicians and hospitals currently respond to a patient's demand for or refusal of treatment by a physician of a particular race. It begins by examining the advent of the doctrine of informed consent, its roots in the law of battery, and the subsequent formulation of the right to refuse unwanted care. It then sets forth the aims and concerns that prompted the U.S. Congress to enact EMTALA and the ways in which this law shapes decisionmaking in the hospital context with respect to accommodating patients' racial preferences.

### A. Informed Consent

The doctrine of informed consent, which is based on the notion of individual autonomy, has guided virtually all modern physician–patient interactions concerning treatment decisions and has paved the way for the formulation of new patient-centered approaches to medicine.<sup>43</sup> The doctrine evolved as a means of addressing

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41. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 281 (1990) (holding that a competent patient has a Fourteenth Amendment due process liberty interest in refusing unwanted medical treatment, including life sustaining treatment, and upholding the use of the clear and convincing evidence standard in determining the patient's wishes with respect to medical treatment).

42. See *Gatewood v. Wash. Healthcare Corp.*, 933 F.2d 1037, 1039 (D.C. Cir. 1991) (explaining that hospitals "patient dump[]" when "emergency rooms deny uninsured patients the same treatment provided paying patients," and observing that "[r]eports of patient dumping rose in the 1980s, as hospitals, generally unencumbered by any state law duty to treat, faced new cost containment pressures combined with growing numbers of uninsured and underinsured patients").

43. See Christine Laine & Frank Davidoff, *Patient-Centered Medicine: A Professional Evolution*, 275 J. AM. MED. ASS'N 152, 152–53 (discussing the "striking" shift in physician attitude toward patient awareness and participation in medical decisionmaking).

abuses and the fundamental knowledge differential between physician and patient that underlies the inequalities inherent in the treatment relationship.<sup>44</sup>

Until the middle of the twentieth century, the treatment received by patients in hospitals was far from ideal. According to George Annas, the hospital was “a human rights wasteland,” where the care of patients ranged from benign paternalism to medical experimentation without consent or the possibility of therapeutic benefit.<sup>45</sup> During this period, medical professionals operated under the assumption that medicine was primarily a scientific endeavor, and that physicians—because of their knowledge, experience, and expertise—were uniquely positioned to make decisions regarding their patients’ best interests.<sup>46</sup> According to this ethos, patients had neither the interest nor the ability to participate in medical decisionmaking.<sup>47</sup> Thus, physicians routinely refused to counsel patients about important medical treatment options,<sup>48</sup> did not inform patients of their prognosis, particularly when the chance of survival was low,<sup>49</sup> ignored patients’ refusal of life-sustaining treatment, and failed to consult patients when exams, tests, or procedures were conducted primarily or solely to educate medical students.<sup>50</sup>

These abuses were particularly pronounced for African American patients, who, until the 1960s, received health services primarily at large public hospitals, which were the training grounds for inexperienced medical students, interns, and residents.<sup>51</sup> People of color and members of disadvantaged or vulnerable groups were also often used as training material.<sup>52</sup> One particularly infamous example is the Tuskegee syphilis study, in which nearly four hundred African American men with syphilis were systematically denied known, effective medical remedies and

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44. See JANET L. DOLGIN & LOIS L. SHEPHERD, *BIOETHICS AND THE LAW* 57 (2d ed. 2009); MARK A. HALL ET AL., *HEALTH CARE LAW AND ETHICS* 197 (7th ed. 2007).

45. See GEORGE J. ANNAS, *JUDGING MEDICINE* 4–26 (1988). The two early and foundational accounts of dangerous human experimentation conducted without consent are Henry K. Beecher, *Ethics and Clinical Research*, 274 *NEW ENG. J. MED.* 1354 (1966), and M.H. PAPPWORTH, *HUMAN GUINEA PIGS: EXPERIMENTATION ON MAN* (1967).

46. See Marc A. Rodwin, *Patient Accountability and Quality of Care: Lessons From Medical Consumerism and the Patients’ Rights, Women’s Health and Disability Rights Movements*, 20 *AM. J.L. & MED.* 147, 150 (1994).

47. *Id.* at 150–51.

48. *Id.* at 151.

49. See generally Naoko T. Miyaji, *The Power of Compassion: Truth-Telling Among American Doctors in the Care of Dying Patients*, 36 *SOC. SCI. & MED.* 249 (1993).

50. Rodwin, *supra* note 46, at 151.

51. See SMITH, *supra* note 2, at 27. This was so because of a symbiotic relationship between medical schools, teaching hospitals, and state and local financing for the indigent. See *id.*

52. See BYRD & CLAYTON, *supra* note 1, at 206 (“[B]lack, public aid populations became ‘training material’ for the medical school and research infrastructure . . .”).

were not informed that they were treated for research, rather than diagnostic, purposes.<sup>53</sup> Sustained from 1932 to 1972, the Tuskegee study was the longest experiment in withholding treatment from human subjects in medical history.<sup>54</sup> Ultimately, this and several other shocking examples of physician paternalism and deceit<sup>55</sup> led to the emergence in the late 1960s and early 1970s of the patients' rights movement and the advent of the modern doctrine of informed consent, which has empowered patients and changed the attitude of a new generation of physicians toward their patients.<sup>56</sup>

Today, physicians are required to obtain a patient's informed approval prior to performing treatment and must disclose information about the risks of the proposed treatment, the alternatives, and the risks of the alternatives. This mandatory information transfer from physician to patient not only safeguards the patient's interests and autonomy but also protects the patient's essential status as a human being, prevents fraud and duress, encourages healthcare providers to consider their decisions carefully, and fosters rational decisionmaking by the patient.<sup>57</sup> By

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53. See JESSICA W. BERG ET AL., *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* 255 (2d ed. 2001). The Tuskegee syphilis study continued well after penicillin became available to treat the disease. *Id.* For more information about the study, see FRED D. GRAY, *THE TUSKEGEE SYPHILIS STUDY: THE REAL STORY AND BEYOND* (1998); JAMES H. JONES, *BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT* (1981); William J. Curran, *The Tuskegee Syphilis Study*, 289 *NEW ENG. J. MED.* 730 (1973); and Robert M. White, *Unraveling the Tuskegee Study of Untreated Syphilis*, 160 *ARCHIVES INTERNAL MED.* 585 (2000).
54. See SMITH, *supra* note 2, at 25.
55. In one high-profile case, a patient successfully sued her physician, who, after informing her that he intended only to mend a few cervical and rectal tears, instead removed entirely her ovaries and uterus. See *Pratt v. Davis*, 79 N.E. 562, 563–64 (Ill. 1906). In another case, a surgeon extracted a patient's fibroid tumor despite the fact that she had explicitly refused surgery and had agreed only to an examination under ether. *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914). In yet another case, a surgeon, when asked about the risks of proposed hand surgery, reassured the patient that there was "nothing to it," and then conducted surgery that left the patient's hand permanently paralyzed. *Hunt v. Bradshaw*, 88 S.E.2d 762 (N.C. 1955).
56. See Alan Meisel, *Managed Care, Autonomy, and Decisionmaking at the End of Life*, 35 *HOUS. L. REV.* 1393, 1398–1400 (describing the advent of informed consent as coinciding with the rise of "citizen autonomy" movements in the 1960s, including the civil rights, students' rights, children's rights, spousal rights, and elder rights movements); see also GEORGE J. ANNAS, *AM. CIVIL LIBERTIES UNION, THE RIGHTS OF PATIENTS* 1–16 (2d ed. 1992) (explaining the patient rights movement); Mark A. Hall, *The Legal and Historical Foundations of Patients as Medical Consumers*, 96 *GEO. L.J.* 583, 586 (2008); Carol B. Liebman, *Medical Malpractice Mediation: Benefits Gained, Opportunities Lost*, 74 *LAW & CONTEMP. PROBS.* 135, 149 (2011); Benjamin Moulton & Jaime S. King, *Aligning Ethics With Medical Decision-Making: The Quest for Informed Patient Choice*, 38 *J.L. MED. & ETHICS* 85, 86 (2010); Wendy E. Parmet, *Unprepared: Why Health Law Fails to Prepare Us for a Pandemic*, 2 *J. HEALTH & BIOMED. L.* 157, 167 (2006).
57. Alexander Morgan Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 *U. PA. L. REV.* 340, 364–76 (1974).

rendering the physician–patient relationship less hierarchical and more dialogic, the informed consent mandate enables healthcare providers to perform with increased sensitivity to a patient’s emotional needs, cognitive ability, and actual comprehension.

## B. Common Law Battery

The theoretical underpinnings of the informed consent doctrine emerged from the law of battery, which safeguards a patient’s physical integrity. The law of battery protects patients from unwanted or harmful physical contacts. The patient has to demonstrate only that she did not consent to the touching that occurred, which includes the provision of medical treatment by an unwanted medical provider.<sup>58</sup> Hence, to bring an action in battery, a patient must simply prove that any of the following occurred: an unconsented-to provider performed the desired procedure, an unconsented-to treatment or touching occurred, the healthcare provider performed a completely different procedure from that for which consent was given, the provider failed to explain the nature or character of a particular procedure that had been performed, or the provider performed a procedure on the wrong area of the body. Proof of physical injury is not necessary under the battery doctrine.<sup>59</sup> Rather, the focus is on the patient’s right to be free from unconsented-to touching.

Because of the very patient-friendly nature of the battery doctrine, courts in some jurisdictions sought to provide more freedom and protection to medical professionals while promoting patient self-determination and autonomy in medical decisionmaking.<sup>60</sup> They did so, beginning in the 1970s, by limiting the scope of the battery doctrine while establishing the modern doctrine of informed consent as a

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58. See *Mohr v. Williams*, 104 N.W. 12 (Minn. 1905) (holding that good intentions were not a defense to a battery claim in a situation in which a patient consented to operation on her right ear, but her physician operated on the left ear instead after determining that it was in worse condition). Informed consent differs from battery to the extent that a standard informed consent claim assumes that the patient has given technical consent to being touched by the defendant but that consent would not have been given if the physician had appropriately disclosed the risks of the procedure. See DAVID ORENTLICHER ET AL., *BIOETHICS AND PUBLIC HEALTH LAW* 170 (2d ed. 2008).

59. By comparison, under a *negligence theory* or under the *informed consent doctrine*, the plaintiff must show that he would have declined a procedure if he had known all the details and risks.

60. See L. Song Richardson, *When Human Experimentation Is Criminal*, 99 J. CRIM. L. & CRIMINOLOGY 89, 96–97 (2009). Medical malpractice reform in some jurisdictions has included abolishing informed consent’s battery basis altogether. In other jurisdictions, such as Arizona, for example, the highest court has held a malpractice reform statute unconstitutional on the grounds that the state constitution established a fundamental right to bring battery actions against a physician based on a common law theory of battery. See *Duncan v. Scottsdale Med. Imaging, Ltd.*, 70 P.3d 435, 443 (Ariz. 2003).

more balanced alternative.<sup>61</sup> Today, disclosure, respect for patients' autonomous decisionmaking, and the norms established by the battery doctrine are understood as fundamental medical ethics requirements. These principles now undergird federal regulations on human experimentation and guide virtually all healthcare interactions, including the right to refuse unwanted medical treatment and the refusal of treatment by an unwanted physician.<sup>62</sup>

### C. The Refusal of Unwanted Medical Care

Informed consent rules and the battery doctrine form the foundation of a rich jurisprudence on the right to refuse medical treatment, which in turn informs how physicians and hospitals respond to a patient's demands or refusals to be treated by a physician of a particular race.<sup>63</sup> A competent patient—or a patient's legally designated surrogate decisionmaker—has a common law and constitutionally protected right to refuse unwanted medical treatment.<sup>64</sup> It follows, then, that a competent patient has the right to refuse the care of a particular healthcare provider, and informed consent rules and the law of battery dictate that the patient's wishes should control.

In any situation in which a patient refuses medical treatment, the healthcare institution must first determine whether the patient is competent to make such a decision.<sup>65</sup> If the institution deems the patient competent, then it must respect her wishes and cease all treatment. Here, the focus is not on the reasonableness of the patient's refusal but rather on the patient's preference.<sup>66</sup> During the determination of competence, or at any other time, it may appear as though the patient is not re-

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61. See Andrew Jameton, *Ethical Issues of Information Disclosure*, in 3 *ENCYCLOPEDIA OF BIOETHICS* 1225, 1226 (Warren T. Reich ed., rev. ed. 1995).

62. See *id.* at 1227.

63. See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990); *In re Jobes*, 529 A.2d 434 (N.J. 1987); *In re Conroy*, 486 A.2d 1209 (N.J. 1985).

64. *Cruzan*, 497 U.S. at 278, 280.

65. *Id.* A staff physician or psychologist typically determines competence. If the patient is deemed incompetent, then a member of the patient's family or a designated surrogate decisionmaker will be selected to make healthcare decisions on behalf of the patient. Although some might argue that demanding or refusing treatment from a physician of a particular race constitutes a form of incompetence, such preferences do not necessarily indicate incompetence under the relevant standard. The dominant test used to determine competence does not focus on competence as a social construct but instead asks whether the patient has demonstrated actual understanding of the ramifications of his or her decision. The physician has an obligation to educate the patient and directly ascertain whether the patient has in fact understood. If this test is met then the patient has provided informed consent. See HALL ET AL., *supra* note 44, at 545.

66. *Cruzan*, 497 U.S. at 278.



fusing care per se but is instead refusing to receive treatment from a particular healthcare provider for prejudiced reasons. In that case, standard medical ethics procedures require the hospital to assess whether there are underlying factors that may have prompted the request (such as determining whether the patient is experiencing pressure from family members) and, if so, whether they can be addressed through means other than acceding to the patient's biases (such as through the provision of counseling).<sup>67</sup>

If, however, these factors are absent and the competent patient in the hospital setting cannot be swayed with respect to her demand for or refusal of a provider of a particular race, then the objected-to provider has a legal obligation to stop providing care immediately, and medical ethics counsel that the patient's preferences should be accommodated.<sup>68</sup>

#### D. EMTALA

The cumulative effect of these legal doctrines and medical ethics default rules on the practice of hospitals accommodating patients' racial preferences is compounded by EMTALA<sup>69</sup> which imposes specific treatment obligations on Medicare-participating hospitals offering emergency services.<sup>70</sup> In 1986, Congress enacted EMTALA because of concerns about widespread patient dumping—hospitals' denial of emergency care to the indigent, including the transfer or discharge of emergency patients on the basis of high anticipated diagnosis or treatment costs.<sup>71</sup> The law creates a duty of hospitals to perform a medical screening examination when requested by an individual who arrives in the emergency department in order to determine whether an emergency medical condition exists or whether the individual is experiencing active labor.<sup>72</sup> EMTALA applies to anyone in need of

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67. Cf. Jacob M. Appel, *The Dangers of the Underprivileged Ethicist: Revising the Rules of Evidence After the Bioethics Revolution*, 42 N.M. L. REV. 1, 7–8 (2012) (describing the ethics consultation process).

68. See Aasim I. Padela & Imran R.A. Punekar, *Emergency Medical Practice: Advancing Cultural Competence and Reducing Health Care Disparities*, 16 ACAD. EMERGENCY MED. 69, 71 (2008).

69. Pub. L. No. 99-272, § 9121(b), 100 Stat. 82, 164–67 (1986) (codified as amended at 42 U.S.C. § 1395dd (2006)).

70. 42 U.S.C. § 1395dd.

71. See H.R. REP. NO. 99-241, pt. 1, at 27 (1986) (reflecting congressional intent to prevent patient dumping with EMTALA), reprinted in 1986 U.S.C.C.A.N. 579, 605; see also *Burditt v. U.S. Dep't of Health & Human Servs.*, 934 F.2d 1362 (5th Cir. 1991) (enforcing EMTALA's antidumping provisions for the first time).

72. See *Burditt*, 934 F.2d at 1370; see also 42 U.S.C. § 1395dd. The law defines an "emergency medical condition" as one that is manifest "by acute symptoms of sufficient severity . . . such that the absence of immediate medical attention could reasonably be expected to result in: placing [the patient's

medical treatment, regardless of citizenship, legal status, or ability to pay.<sup>73</sup>

Notably, the EMTALA-imposed duties apply not only to those who come to an emergency department presenting an emergency medical condition but also to any individual who arrives anywhere on the hospital premises requesting medical treatment, irrespective of whether the person is visibly in need of emergency care.<sup>74</sup> The law establishes no duty to provide continuing medical treatment; however, if, during the EMTALA-mandated medical screening an emergency medical condition or active labor is diagnosed, then it is incumbent on the hospital either to stabilize the individual and provide emergency care or to arrange to transfer the patient, with her consent, to a facility that is able to provide appropriate treatment.<sup>75</sup> A physician must certify in writing that the medical benefits of the transfer outweigh the risks to the patient. In addition, the receiving hospital must be capable of providing the needed treatment and must agree to the transfer.<sup>76</sup> A patient also has the right under EMTALA to request a transfer.<sup>77</sup> Before the hospital can exercise this option, however, it must first provide the treatment necessary to minimize the risks posed by the transfer.<sup>78</sup>

### E. The Operation of the Default Legal Regime

Informed consent obligations, the right to refuse unwanted medical treatment, the law of battery, and the EMTALA-mandated duty may together present an ethical bind and potential legal liability for hospitals dealing with a patient who wants to obtain or avoid care by a physician of a particular race. Hospital emergency departments serve diverse patient populations, including individuals too impoverished to obtain basic healthcare services elsewhere and individuals who require urgent medical treatment. Patients who seek treatment in hospital emergency departments are typically in poor health and vulnerable, and may be in desperate need of acute care. These individuals have few, if any, alternate venues where they can receive the type of urgent, and often life-saving, treatment offered in a hospital setting. If a patient who desires treatment will not yield in his preference for a

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health] . . . in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." *See id.* § 1395dd(e)(1)(A).

73. *See id.* §§ 1395dd(a).

74. As mentioned above, this applies to hospitals that receive Medicare funds and that provide emergency services. *See id.* §§ 1395dd(a), (b)(1).

75. *See id.* § 1395dd(b)(1).

76. *See id.* § 1395dd(c)(1).

77. *See id.* § 1395dd(b)(1)(B).

78. *See id.* § 1395dd(c)(2)(A).

provider of a particular race and will not agree to a transfer, then the hospital is faced with the dilemma of choosing between (1) having a physician unwanted by the patient forcibly perform the EMTALA-mandated medical screening, thereby violating informed consent and battery laws, and (2) rejecting the patient in violation of EMTALA, thereby risking liability and the chance that this decision will cause the patient to suffer, experience grievous harm, or die.

Further, hospital emergency departments operate under significant time pressures, as often the needs of individuals seeking treatment are immediate.<sup>79</sup> As a result, even the delay caused by a hospital deciding between these options could result in death or in imminent, serious bodily injury to the patient and thus contravene the physician's ethical duty to provide appropriate treatment. Thus, in this legal regime, the failure to accede to patients' racial preferences presents healthcare providers with two equally vexing options, both of which carry the risk of legal sanction.

Although the accommodation of patient racial preference in the hospital setting appears to be consistent with EMTALA and medical ethics norms and practice, does this accommodation violate accepted notions of racial equality? Part III addresses this question in detail.

### III. DOES THE LAW SPEAK TO THIS ISSUE?: PATIENT PREFERENCE DISCRIMINATION AND THE 1964 CIVIL RIGHTS ACT

The question looming in any inquiry into the propriety of hospitals accommodating patients' racial preferences with respect to their choice of physician is whether the practice is legal. Indeed, it is difficult to imagine preferences of this sort indulged in any other sector. What is so unique about medicine and the hospital setting that we would accept uses of race that would clearly be deemed problematic, even offensive, in other arenas? In determining the legal legitimacy of this practice, we must look to antidiscrimination laws for guidance.

Titles II, VI, and VII of the CRA, the most prominent civil rights statute enacted since Reconstruction, outlawed discrimination against individuals based on race, color, or national origin.<sup>80</sup> This broadly remedial, landmark legislation

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79. Padela & Punekar, *supra* note 68, at 71.

80. Civil Rights Act of 1964, 42 U.S.C. §§ 2000a(a), 2000d, 2000e-2(a). Titles II and VII also protect against discrimination based on religion. *See* 42 U.S.C. §§ 2000a(a), 2000e-2(a). Titles II, VI, and VII do not specifically define race but rather rely on the classifications delineated in the U.S. Office of Management and Budget's (OMB) Directive No. 15. The OMB recognizes the following categories: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino,

was passed at a time when discrimination was rampant and practiced openly in virtually every aspect of public life. Individuals were routinely denied access to public establishments because of their membership in a disfavored minority group, and with rare exceptions, health and social service organizations in the United States were segregated by race.<sup>81</sup>

Antidiscrimination laws have been quite effective at curbing blatant race discrimination in most public contexts, but does their reach extend to hospitals yielding to patients' racial biases? This Part examines the antidiscrimination laws that bear on this practice, including Titles II, VI, and VII of the CRA. It contends that these laws fail to offer a clear legal directive on the issues of healthcare providers accommodating patients' racial preferences, and that this practice does not, in fact, constitute the type of invidious discrimination envisioned by the drafters of the CRA. This Part further argues that although acceding to patients' race-based requests may appear to contravene antidiscrimination norms, it is actually consistent with principles of antisubordination and racial equality.

#### A. Customer Preference Discrimination in Public Accommodations Under Title II

Title II of the CRA proscribes discrimination by a commercial entity yielding to the racial preferences of its customers.<sup>82</sup> It covers discrimination based on race, color, religion, or national origin by public accommodations "affecting interstate commerce," which the law defines as hotels, motels, restaurants, theaters, gas stations, bars, recreation areas, and places of exhibition or entertainment.<sup>83</sup> The

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Native Hawaiian or other Pacific Islander, and White. *See* Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, 62 Fed. Reg. 58,782, 58,782 (Oct. 30, 1997).

81. *See* SMITH, *supra* note 2, at 12. Until the mid-twentieth century, the overwhelming majority of orphanages, private charitable hospitals, local almshouses, and state facilities served only whites. *See id.* Congress legitimized healthcare segregation when, in 1946, it enacted the Hospital Survey and Construction Act (the Hill-Burton Act), Pub. L. No. 79-725, 60 Stat. 1041 (1946) (codified as amended at 42 U.S.C. §§ 291 to 291o-1), which authorized the construction of segregated hospitals and nursing homes. By March 1964, of the more than three thousand Hill-Burton construction projects, 104 segregated facilities had been built: eighty-four for whites only and twenty for blacks. *See* BYRD & CLAYTON, *supra* note 1, at 267.

82. *See* 42 U.S.C. § 2000a(a).

83. *See* 42 U.S.C. § 2000a(b), (b)(4) (covering "[e]stablishments affecting interstate commerce or supported in their activities by State action as places of public accommodation; lodgings; facilities principally engaged in selling food for consumption on the premises; gasoline stations; places of exhibition or entertainment; [and] other covered establishments," including "any establishment which is physically located within the premises of any establishment otherwise covered by this subsection, or within the premises of which is physically located any such covered establishment, and which holds itself out as serving patrons of such covered establishment").

law was enacted specifically to grant racial minorities full access to public facilities and precludes the owners of such facilities from justifying discrimination by arguing that customers prefer to be served by or share the premises with only individuals of a particular race. Hence, a restaurant would violate Title II if it succumbed to a customer request for a waiter of a race different from that of the one assigned.

Title II clearly prohibits customer preference discrimination, and while the norms and goals that structure Title II might, at first glance, appear applicable to the hospital context, the Act does not govern this practice because “hospitals are not listed among the establishments to which Title II applies.”<sup>84</sup> Indeed, courts have uniformly held that Title II “sets forth a comprehensive list of establishments that qualify as a place of public accommodation and in so doing excludes from its coverage those categories of establishments not listed.”<sup>85</sup> The “establishments covered by the federal statute do not include hospitals”;<sup>86</sup> therefore, Title II cannot be understood to govern the practice of hospitals complying with patients’ requests for physicians of the same race.

## B. Customer Preference Discrimination in Employment Under Title VII

Title VII of the CRA is the primary federal statute addressing employment discrimination. It specifically prohibits employers from discriminating, by motivation or impact, against persons because of race, color, religion, sex, or national origin; and it applies to discrimination with respect to “compensation, terms, conditions, or privileges of employment.”<sup>87</sup>

The law also makes clear that an employer’s wish to cater to the actual or imagined discriminatory preferences of its clientele is generally not a valid defense for treating employees differently based on protected characteristics.<sup>88</sup> Thus, for ex-

84. *Foster v. Howard Univ. Hosp.*, No. Civ.A. 06-244, 2006 WL 2938701, at \*2 (D.D.C. Oct. 13, 2006); *see also Verhagen v. Olarte*, No. 89 Civ. 0300, 1989 WL 146265, at \*4 (S.D.N.Y. Nov. 21, 1989) (observing that “Congress went to the effort of specifying those establishments which constitute places of public accommodation under § 2000a”).

85. *Denny v. Elizabeth Arden Salons, Inc.*, 456 F.3d 427, 431 (4th Cir. 2006) (citation omitted) (internal quotation marks omitted); *see also Kalantar v. Lufthansa German Airlines*, 402 F. Supp. 2d 130, 139 (D.D.C. 2005) (dismissing the Title II claim brought by an Iranian airline passenger because none of the establishments enumerated in the statute “even remotely resembles an airline, or indeed any other vehicle or mode of transportation”).

86. *Verhagen*, 1989 WL 146265, at \*4.

87. 42 U.S.C. § 2000e-2(a)(1).

88. *See id.* § 2000e-2(a)(2); *see also* Mark Kelman, *Market Discrimination and Groups*, 53 STAN. L. REV. 833, 841 (2001) (“Insofar as the employer . . . fails to give the employee or customer something he desires because of traits that are irrelevant to his economic function, he is breaching the duty to avoid simple discrimination.”).

ample, a provider of security services cannot bow to customer preferences for male security guards by reassigning women to inconvenient, lower-paid positions;<sup>89</sup> nor can a telephone marketing firm succumb to a client request that only black employees call black households and white employees call white households.<sup>90</sup>

The accommodation of patients' racial preferences in the hospital context, however, is decidedly not the typical Title VII scenario; nor does it conform neatly with the types of discrimination that Title VII was enacted to address, which may explain why physicians have not objected to, and indeed have continued to indulge, patients' racial preferences. In fact, there is no case law directly addressing this practice. The only case that comes close to broaching this issue is *Chaney v. Plainfield Healthcare Center*,<sup>91</sup> in which a black certified nursing assistant (CNA) sued her employer, a nursing home, for race discrimination under Title VII.<sup>92</sup> She alleged that she was subjected to a racially hostile work environment and based her claim, in part, on the fact that the nursing home distributed daily a written assignment schedule for all employees that indicated each patient who "prefers no black CNAs."<sup>93</sup> The Seventh Circuit held that Title VII prohibits nursing homes from making staffing decisions based on their residents' racially biased wishes with respect to CNAs.<sup>94</sup>

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89. See *EEOC v. Guardsmark, LLC*, No. H-09-3062, 2010 WL 5391269, at \*3 (S.D. Tex. Dec. 22, 2010); see also *Fernandez v. Wynn Oil Co.*, 653 F.2d 1273, 1274 (9th Cir. 1981) (holding that the company's contention that its "Latin American clients would react negatively to a woman vice-president" did not constitute a valid justification under Title VII for the company's failure to promote a female employee to the position); *Diaz v. Pan Am. World Airways, Inc.*, 442 F.2d 385 (5th Cir. 1971) (holding that the airline's refusal to hire males as flight attendants violated Title VII); *Wilson v. Sw. Airlines, Inc.*, 880 F.2d 807 (5th Cir. 1989) (holding that an airline's policy of hiring only female flight attendants violated Title VII).

90. *Ferrill v. Parker Grp., Inc.*, 168 F.3d 468, 477 (11th Cir. 1999) (holding that a client's request that the telemarketing firm "race match" its get-out-the-vote calls to households by requiring black employees to call black voters using a "black" script, while requiring white employees to call white voters using a "white" script, provided no defense to a violation of the CRA); see also *Johnson v. Zema Sys. Corp.*, 170 F.3d 734, 744 (7th Cir. 1999) (invalidating an employer's maintenance of a segregated sales force under Title VII); *Bellwood v. Dwivedi*, 895 F.2d 1521, 1530-31 (7th Cir. 1990) (discussing how Title VII would preclude an employer's refusal to hire African American workers because the employer believed that his customers did not like African Americans); *Jatczak v. Ochburg*, 540 F. Supp. 698 (E.D. Mich. 1982) (holding that an employer cannot rely on gender or racial categories when hiring a social worker whose work would include serving as a positive role model for young urban black men); EEOC COMPLIANCE MANUAL, SECTION 15: RACE AND COLOR DISCRIMINATION 15-12 (2006) (explaining that Title VII is violated when an employer decides not to hire an African American aide because the employer believes that its non-African American clientele would be uncomfortable with an African American aide).

91. 612 F.3d 908 (7th Cir. 2010).

92. *Id.* at 910.

93. *Id.*

94. *Id.*

Although on its face this case bears a resemblance to physicians accommodating patients' racial preferences in the hospital setting, it is distinguishable in ways that may explain why physicians are not challenging this practice despite its prevalence. Most notably, unlike the situation in *Chaney*, the decision to accede to patients' requests for same-race physicians is made not by hospital administrators but rather by physicians who are deciding among themselves how best to meet each patient's needs. As I explain, physicians' willingness to accommodate is likely due to the unique nature of the physician–patient relationship, which contrasts sharply with that of a CNA and nursing home resident.

For example, in *Chaney*, the court appropriately rejected the nursing home's attempt tacitly to exploit a narrow exception to Title VII's antidiscrimination mandate. This exception, known as a bona fide occupational qualification (BFOQ), allows employers openly and legitimately to base employment decisions on sex, religion, or national origin—but not race, which is explicitly excluded.<sup>95</sup> The specific characteristic or attribute must be necessary to the ordinary operation of the particular business or enterprise.<sup>96</sup> More than simply job related, the qualification must be “compelling,” “overriding,” or inextricably linked to the central mission or essence of the job.<sup>97</sup> Thus, the BFOQ defense would permit a theater to hire actors on the basis of gender, or an advertiser of men's clothing lawfully to advertise exclusively for and hire only male models.<sup>98</sup> The employer bears the responsibil-

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95. 42 U.S.C. § 2000e-2(e) (2006).

96. *See id.* (requiring the discrimination to be “reasonably necessary to the normal operation of that particular business or enterprise”); *see also* *Dothard v. Rawlinson*, 433 U.S. 321, 335–37 (1977) (finding that a maximum security prison, where males were segregated on the basis of their level of dangerousness, was permitted under Title VII's BFOQ to have a policy that precluded the hiring of women as correctional counselors in a contact position with inmates).

97. *See* *Huisenga v. Opus Corp.*, 494 N.W.2d 469, 472–73 (Minn. 1992); *Kraft, Inc. v. State*, 284 N.W.2d 386, 388 (Minn. 1979); Melissa K. Stull, *Permissible Sex Discrimination in Employment Based on Bona Fide Occupational Qualifications (BFOQ) Under § 7039(e)(1) of Title VII of Civil Rights Act of 1964 (42 USCS § 2000e-2(e)(1))*, 110 A.L.R. FED. 28 (1992); Kimberly A. Yuracko, *Private Nurses and Playboy Bunnies: Explaining Permissible Sex Discrimination*, 92 CALIF. L. REV. 147, 184–91 (2004); Amy Kapczynski, Note, *Same-Sex Privacy and the Limits of Antidiscrimination Law*, 112 YALE L.J. 1257, 1259–60 (2003).

98. The Equal Employment Opportunity Commission (EEOC) guidelines emphasize both the narrowness of the BFOQ defense and its general permissibility for authenticity purposes, such as hiring women to model maternity clothes in advertisements. *See* 29 C.F.R. § 1604.2(a) (2012); *see also* Paulette M. Caldwell, *A Hair Piece: Perspectives on the Intersection of Race and Gender*, 1991 DUKE L.J. 365; Angela Onwuachi-Willig, *Another Hair Piece: Exploring New Strands of Analysis Under Title VII*, 98 GEO. L.J. 1079 (2010); Russell K. Robinson, *Casting and Caste-ing: Reconciling Artistic Freedom and Antidiscrimination Norms*, 95 CALIF. L. REV. 1 (2007).

ity of demonstrating that all or substantially all members of the group(s) excluded from the job would be unable to perform the duties of the position.<sup>99</sup>

The BFOQ defense may also be used as a defense against a charge of accommodating customer preferences in a very limited number of circumstances in which customer privacy is a concern.<sup>100</sup> Thus, for example, although the BFOQ defense will not serve as a valid justification for an airline to hire only women as flight attendants to comply with male customer preferences,<sup>101</sup> the privacy interests of psychiatric patients can justify a BFOQ for personal hygiene attendants of the same sex.<sup>102</sup> To this end, courts have held that for certain workers, such as nursing assistants, hospital delivery room nursing staff, and others involved in assisting individuals with dressing, disrobing, or bathing, gender may be a legitimate BFOQ for accommodating patients' privacy or modesty interests.<sup>103</sup> In *Chaney*, however, the

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99. See, e.g., *UAW v. Johnson Controls, Inc.*, 499 U.S. 187, 207 (1991) (stating that the employer may not exclude women of childbearing age from certain jobs that involve the handling of lead even though the employer alleges that lead could be harmful to fetuses).
100. See *Jennings v. N.Y. State Office of Mental Health*, 786 F. Supp. 376, 387 (S.D.N.Y. 1992); *Backus v. Baptist Med. Ctr.*, 510 F. Supp. 1191, 1193–96 (E.D. Ark. 1981); *Fesel v. Masonic Home of Del., Inc.*, 447 F. Supp. 1346, 1350–51 (D. Del. 1978), *aff'd without opinion*, 591 F.2d 1334 (3d Cir. 1979). To a lesser extent, courts have also permitted sex-based customer preference discrimination in cases where explicit sexuality is a central feature of the business or enterprise, such as strip clubs. See, e.g., *St. Cross v. Playboy Club, Inc.*, No. CSF 22618-70, Appeal No. 773 (N.Y. State Human Rights Appeals Bd. Dec. 17, 1971); *Weber v. Playboy Club, Inc.*, No. CSF 22619-70, Appeal No. 774 (N.Y. Human Rights Appeals Bd. Dec. 17, 1971) (holding that Playboy Club, Inc. does not engage in a discriminatory practice when hiring female employees based on physical attributes appealing to its customers); 3 LEX K. LARSON ET AL., *EMPLOYMENT DISCRIMINATION* § 43.02[2], at 43-5 (2d ed. 1992) (discussing burlesque, go-go, and chorus-line dancers); Larry Alexander, *What Makes Wrongful Discrimination Wrong? Biases, Preferences, Stereotypes, and Proxies*, 141 U. PA. L. REV. 149, 205–06 (1992) (addressing strip clubs); Yuracko, *supra* note 97, at 181.
101. See, e.g., *Diaz v. Pan Am. World Airways*, 442 F.2d 385 (5th Cir. 1971); see also *Wilson v. Sw. Airlines Co.*, 517 F. Supp. 292, 299–304 (N.D. Tex. 1981) (finding that Title VII's BFOQ defense was not available to a defendant airline that sought to pander to male business travelers by hiring only female flight attendants and dressing them in "hot pants").
102. *Local 567, AFSCME v. Michigan*, 635 F. Supp. 1010, 1013 (E.D. Mich. 1986).
103. See, e.g., *Healey v. Southwood Psychiatric Hosp.*, 78 F.3d 128, 133 (3d Cir. 1996) (holding that BFOQ defense was established where psychiatric hospital staff treated emotionally disturbed and sexually abused children and adolescents who "often [had to be] accompanied to the bathroom, and sometimes . . . bathed"); *Wilson v. Chertoff*, 699 F. Supp. 2d 364, 372–73 (D. Mass. 2010) (determining that the Transportation Security Administration may engage in gender-based employment actions to allow for same-sex screening for body pat-downs); *Jones v. Hinds Gen. Hosp.*, 666 F. Supp. 933, 935 (S.D. Miss. 1987) ("The job duties of male and female nurse assistants and male orderlies often require that such employee view or touch the private parts of their patients."); *EEOC v. Mercy Health Ctr.*, No. Civ. 80-1374-W, 1982 WL 3108 (W.D. Okla. 1982) (holding that a hospital may refuse to hire men to work as nurses in the labor and delivery units without violating Title VII because female patients would not feel comfortable with male nurses); *Brooks v. ACF Indus., Inc.*, 537 F. Supp. 1122, 1133 (S.D. W. Va. 1982) (holding that the male gender was a BFOQ for washroom and bathhouse attendants); *Fesel*, 447 F. Supp. at 1352–53 (stating that sex is a perm-



court correctly held that race is not a relevant factor to consider in addressing privacy concerns, nor is it relevant to the work of CNAs.<sup>104</sup>

The practice of physicians accommodating patients' racial preferences, in contrast, has not been challenged by physicians nor has it been framed as a BFOQ. This may be due to the fact that unlike the prototypical BFOQ situation, the relationship between physician and patient in the hospital context is not defined by issues of personal modesty but is instead fundamentally diagnostic and therapeutic. Thus, if physicians were challenging this practice—and they are not—then they would have to contend not with a BFOQ defense, but perhaps rather a claim based on the intimate, therapeutic, and diagnostic nature of the physician–patient relationship.<sup>105</sup> This relationship, to be effective, is highly dependent on trust, productive communication, mutual respect, cooperation, participatory decisionmaking, and caring.<sup>106</sup> A patient must be willing to speak candidly about personal and potentially uncomfortable or embarrassing information; to submit to bodily examination, including attention to all manner

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issible BFOQ at a nursing home that “has the responsibility of providing twenty-four hour supervision and care of its elderly guests. Fulfillment of that responsibility necessitates intimate personal care including dressing, bathing, toilet assistance, geriatric pad changes and catheter care. Each of these functions involves a personal touching . . .”).

104. *Chaney v. Plainfield Healthcare Ctr.*, 612 F.3d 908, 910 (7th Cir. 2010).

105. Notably, the statutory argument just explored arguably also has constitutional dimensions that sound in the Supreme Court's intimate association cases. See *Bd. of Dirs. of Rotary Int'l v. Rotary Club*, 481 U.S. 537, 545 (1987); see also *Fair Hous. Council v. Roommate.com, LLC*, 666 F.3d 1216, 1221–22 (9th Cir. 2012) (noting the intimate associational rights of cohabiting nonrelatives). The physician–patient relationship would presumably satisfy the “size, purpose, selectivity, and . . . exclu[sion of others] from critical aspects of the relationship” test set out in the Court's cases. See *Rotary Club*, 481 U.S. at 536. Like other intimate relationships deemed protected by these precedents, it typically involves two individuals and elements of trust, selectivity, communication, and cooperative decisionmaking. See Elizabeth A. Pector, *How Patients Really Choose Their Doctors*, 77 *MED. ECON.* 154 (2000); cf. Jean Abraham et al., *Selecting a Provider: What Factors Influence Patients' Decision-Making?*, 56 *J. HEALTHCARE MGMT* 99, 110 (2011). Patients seeking accommodation of their race-based preferences in care thus might reasonably explore an intimate association claim, though its likelihood of success given cases in other areas is not certain. See *Norwood v. Harrison*, 413 U.S. 455, 469–70 (1973). Importantly, hospitals and other institutions whose actions fall under Title VII and other similar state and local laws could not resort to this claim in defending themselves against actions or policies requiring accommodation of race-based preferences. See *Roberts v. U.S. Jaycees*, 468 U.S. 609, 620 (1984) (holding that the right of intimate association does not apply to “large commercial enterprises”). Hospitals may, however, be able to raise the constitutional claim on behalf of their patients. See *Craig v. Boren*, 429 U.S. 190, 195 (1976).

106. See Cooper et al., *supra* note 20, at 913 tbl.3; Thomas A. LaVeist et al., *Attitudes About Racism, Medical Mistrust, and Satisfaction With Care Among African American and White Cardiac Patients*, 57 *MED. CARE RES. & REV.*, supp. 1, 2000 at 146, 146–47; Michelle van Ryn & Jane Burke, *The Effect of Patient Race and Socio-economic Status on Physicians' Perceptions of Patients*, 50 *SOC. SCI. & MED.* 813, 823 (2000).

of injury and abuse;<sup>107</sup> to confide in and communicate openly with the physician;<sup>108</sup> to rely on the physician's recommendations; and to feel confident in the belief that the physician is acting to advance the patient's best interest.<sup>109</sup> In fact, the absence of these elements may mean the difference between life and death for some patients. To this end, the AMA has consistently and unequivocally maintained that a patient's ability to choose a personal physician is a "prerequisite of optimal care and ethical practice."<sup>110</sup>

Even beyond the intimately therapeutic character of the physician-patient relationship, there is strong empirical support for the medical efficacy of respecting patients' wishes with regard to their choice of physician. Indeed, as I demonstrate in Part IV, several studies show that this practice can benefit some patients tremendously.<sup>111</sup> In addition, physicians overwhelmingly believe that their primary obligation is to provide the best possible care to individual patients since, according

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107. See generally AMA Code of Medical Ethics, Opinion 2.02—Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse (2008), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion202.page> (discussing physicians' duty to ask questions and conduct patient physical examinations with an eye to detecting abuse).
  108. See David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX, 141, 147–48 (1995). Recent data shows that trust is a central element of the physician-patient relationship. See generally Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 469, 478–82 (2002) (providing comprehensive discussion of the nature and significance of trust and discussing empirical research showing that trust has therapeutic benefits, including the placebo effect); Mark A. Hall, *The Importance of Trust for Ethics, Law, and Public Policy*, 14 CAMBRIDGE Q. HEALTHCARE ETHICS 156 (2005) (discussing a growing recognition of the importance of trust and surveying competing public policy theories about trust). See also Robert Gatter, *Faith, Confidence, and Health Care: Fostering Trust in Medicine Through Law*, 39 WAKE FOREST L. REV. 395, 399–400, 416–17 (2004) (noting that "researchers have established a positive correlation between medical trust and certain desirable health-related behaviors" by patients and also questioning the placebo effect); Mark A. Hall, *Can You Trust a Doctor You Can't Sue?*, 54 DEPAUL L. REV. 303 (2005) (discussing the implications of malpractice reform on medical trust); Mark A. Hall & Robert A. Berenson, *Ethical Practice in Managed Care: A Dose of Realism*, 128 ANNALS INTERNAL MED. 395, 396–97 (1998) ("[T]he primary goal of role-based medical ethics [in the context of physician financial incentives] should be the preservation of patients' trust in their physicians. Trust is important primarily because of its therapeutic role, not simply because of its intrinsic, theoretical value.").
  109. See AMA Code of Medical Ethics, Opinion 10.015—The Patient-Physician Relationship (2001) [hereinafter Opinion 10.015], available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.page> ("The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare.").
  110. *Valley Med. Specialists v. Farber*, 982 P.2d 1277, 1282 (Ariz. 1999); see *Ohio Urology, Inc. v. Poll*, 594 N.E.2d 1027, 1030 (Ohio Ct. App. 1991); AMA Code of Medical Ethics, Opinion 9.06—Free Choice (1977), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion906.page>.
  111. See *infra* Part IV.A.

to the AMA Code of Ethics, physicians have “ethical obligations to place patients’ welfare above their own self-interest and above obligations to other groups, and to advocate for their patients’ welfare.”<sup>112</sup> Thus, to the extent that they must occasionally accommodate patients’ racial preferences to satisfy patients’ healthcare needs, then the general sentiment among physicians, as explained by one doctor, is that “[w]hile it can be difficult, . . . emergency physicians are there to serve their patients, not act on desires to make a point and try to correct a patient’s perception of the world.”<sup>113</sup>

In addition, physicians may not be challenging the practice of accommodating patients’ racial preferences because it does not disparately burden physicians of a particular race, as data revealing the racial diversity of the patients making these types of requests may suggest.<sup>114</sup> Several studies have found that when presented with a choice, patients of all racial and ethnic backgrounds tend to choose physicians of their own group, and all racial and ethnic groups express greater satisfaction with the quality of their care when they are racially concordant with their physician.<sup>115</sup> Finally, physicians’ decisions to accommodate may also be based on a belief that patients whose wishes are not respected may be more likely to sue their physicians if something goes wrong.<sup>116</sup> Studies show that patients who dislike or disapprove of their healthcare providers are more likely to file malpractice claims against their providers.<sup>117</sup>

All told, the unique nature of the physician–patient relationship, the fact that this relationship may be constitutionally protected, the significance of race in the therapeutic enterprise, the fact that the accommodation of patients’ racial preferences in the hospital setting does not appear to adversely affect physicians by race, and the evidence demonstrating that acceding to patients’ requests has been shown to increase patient satisfaction and improve care all distinguish this practice from the types of discrimination that Title VII was intended to address.

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112. Opinion 10.015, *supra* note 109.

113. Benton, *supra* note 3, at 23.

114. *Cf.* Padelá et al., *supra* note 3, at 466 (asserting that patients of minority backgrounds had significantly greater accommodation scores than those from majority backgrounds).

115. *See* LaVeist & Nuru-Jeter, *supra* note 22, at 296; Saha et al., *supra* note 21, at 78–79.

116. This observation is based on data obtained through author interviews with physicians from September 2011 through July 2012.

117. *See, e.g.*, H.P. Forster et al., *Reducing Legal Risk by Practicing Patient-Centered Medicine*, 162 ARCHIVES INTERNAL MED. 1217, 1219 (2002) (analyzing several studies and demonstrating that physicians may be able to minimize malpractice claims by treating their patients with respectful and genuine attention); Henry T. Stelfox, *The Relation of Patient Satisfaction With Complaints Against Physicians and Malpractice Lawsuits*, 118 AM. J. MED. 1126, 1131 (2005) (demonstrating that patients are more likely to file malpractice suits against physicians when they are dissatisfied with them).

### C. Title VI of the Civil Rights Act

Title VI of the CRA provides that no person “shall, on the grounds of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.”<sup>118</sup> This law was enacted partly as a means of eradicating de jure racial segregation within and among healthcare facilities.<sup>119</sup> Although Title VI is ambiguous with respect to its scope and practical applications,<sup>120</sup> the statute expressly covers hospitals and targets racially discriminatory actions against actual and potential patients by healthcare institutions, including denial of healthcare benefits and services.<sup>121</sup> Title VI has been a powerful force in eliminating the type of discrimination described at the outset of this Article. The law has never been interpreted as governing the accommodation of patients' racial preferences in federally funded hospitals, however, and there are several reasons to believe that this practice does not fall within the ambit of Title VI.

As a threshold matter, it must be determined who would have standing to bring suit challenging the practice. The patient who is seeking the accommodation is unlikely to challenge the hospital's decision to comply with the request. A physician who sought to challenge a hospital's staffing decision made in response to a patient's request for physician race concordance would be required to raise her claim under Title VII because “any employment practice of any employer . . . except

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118. See 42 U.S.C. § 2000d (2006).

119. See U.S. DEPT OF JUSTICE, TITLE VI LEGAL MANUAL 3–6 (1998), available at [http://www.justice.gov/crt/grants\\_statutes/legalman.pdf](http://www.justice.gov/crt/grants_statutes/legalman.pdf). While Title VI has effectively eliminated de jure racial segregation, the law has been much less successful at eradicating more subtle forms of discrimination and facially neutral policies and practices that may have a disparate impact on minority communities. For example, hospitals limit the number of beds available to Medicaid patients, relocate to wealthier or predominately white neighborhoods or suburbs in which minorities cannot easily access services, such as in *NAACP v. Wilmington Medical Center, Inc.*, 453 F. Supp. 330 (D. Del. 1978), or close or relocate certain services thought to be appealing to low-income patients, such as emergency or obstetrics care. Managed care companies engage in “redlining” and “cherry-picking” practices to exclude high-risk, high-cost patients, including many minorities. See Meridel J. Bulle-Vu, *Statistical Intent: A Post-Sandoval Litigation Strategy for Title VI Impact Cases*, 17 GEO. J. ON POVERTY L. & POLY 461, 466 (2010). In addition, municipalities may convert public and nonprofit healthcare facilities to for-profit status. See Vernellia R. Randall, *Racist Health Care: Reforming an Unjust Health Care System to Meet the Need of African-Americans*, 3 HEALTH MATRIX 127, 150 (1993).

120. See ROYL. BROOKS, CIVIL RIGHTS LITIGATION: CASES AND PERSPECTIVES 204 (2d ed. 2000).

121. See 45 C.F.R. § 80.3(b)(i)–(vi) (2011). For example, the specific discriminatory actions prohibited under Title VI include denying services or benefits, providing inferior services or benefits, segregating services, restricting patients' “enjoyment of any advantage or privileges enjoyed by others” receiving the services or benefits, and discriminating in enrollment or eligibility. *Id.*

where a primary objective of the Federal financial assistance is to provide employment<sup>122</sup> is explicitly exempted from the scope of Title VI.

Further, the U.S. Supreme Court has rejected a private right of action to enforce Title VI's regulations prohibiting disparate impact discrimination.<sup>123</sup> Hence, if a federally funded entity fails to comply with these regulations, Title VI allows only the funding agency to enforce them.<sup>124</sup> However, the practice of accommodating patients' racial preferences has no disproportionate adverse effect on patients of a particular race because the practice does not deny patients the opportunity to enjoy the benefits of, or partake in the services rendered by, a federally funded hospital.

In addition, Title VI applies only to intentional discrimination<sup>125</sup> and explicitly targets racially discriminatory actions by hospitals that deny patients the chance to participate in federally funded healthcare benefits and services.<sup>126</sup> Even if discrimination by patients or hospitals against physicians were within the purview of Title VI, the intent behind indulging patients' requests for a physician of a particular race is not to discriminate against physicians but rather to provide optimal care to each patient. And, ironically, this practice may be one of the best available means of enforcing Title VI's mandate to enable individuals to enjoy the benefits of a covered entity or program, regardless of race, color, or national origin.

Studies are increasingly reporting that the accommodation of patients' racial preferences with respect to their choice of physician in the hospital context may counter the effects of implicit bias, discrimination, and stereotyping by physicians,

122. 42 U.S.C. § 2000d-3. Only federally funded employment programs are subject to Title VI penalties for the type of race or national origin discrimination proscribed by Title VII of the CRA.

123. *See Alexander v. Sandoval*, 532 U.S. 275 (2001).

124. 42 U.S.C. § 2000d-1. Federal agencies may enforce the regulations either by refusing to grant or by terminating funds upon an administrative determination of noncompliance with the regulations. Funding agencies are also required to coordinate their enforcement efforts with the U.S. Attorney General. *See id.*; Exec. Order No. 12,250, 45 Fed. Reg. 72,995 (Nov. 2, 1980).

125. Title VI adopts the Fourteenth Amendment's standard of proof for intentional discrimination. *See Elston v. Talladega Cnty. Bd. of Educ.*, 997 F.2d 1394, 1405 n.11, 1407 n.14 (11th Cir. 1993). Although Title VI expressly provides only for administrative enforcement, the Supreme Court has implied a private cause of action for individuals to enforce both the statute and the implementing regulations that prohibit intentional discrimination. *See Guardians Ass'n v. Civil Serv. Comm'n*, 463 U.S. 582, 597 (1983). In *Guardians*, a majority of the Court held that proof of discriminatory intent is necessary for a violation of the statute itself, while a different majority held that discriminatory impact is sufficient to state some type of claim under Title VI. *See id.* at 608 n.1 (Powell, J., joined by Burger, C.J., concurring); *id.* at 612 (Rehnquist, J., concurring); *id.* at 612 n.1 (O'Connor, J., concurring); *id.* at 642 (Stevens, J., joined by Brennan, J., and Blackmun, J., dissenting). *But see Alexander*, 532 U.S. at 293 (holding that there is no private right of action to enforce the Title VI disparate impact regulations).

126. *See* 45 C.F.R. § 80.3(b)(i)-(vi).

which negatively affect patient health and contribute to the widespread health disparities among racial and ethnic groups in the United States.<sup>127</sup> Health disparities among racial groups are well documented, as overwhelming evidence demonstrates that racial and ethnic minorities experience poorer-quality healthcare than white Americans, even when controlling for factors such as insurance status and income.<sup>128</sup> Life expectancy and infant mortality are both considered important indicators of population health and are critical gauges of access to and quality of medical care, socioeconomic conditions, maternal health, and public health practices.<sup>129</sup> Although life expectancy in the United States increased during the twentieth century, the infant mortality rate for African Americans is up to three times higher than that of other races,<sup>130</sup> and African American life expectancy at birth remains more than four years below that of European Americans.<sup>131</sup> The mortality rate is

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127. See Neil S. Calman, *Out of the Shadow*, 19 HEALTH AFF. 170, 172–74 (explaining how racial prejudices affect and limit patients' healthcare opportunities); Chen et al., *supra* note 21, at 142; Alexander R. Green et al., *Implicit Bias Among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 J. GEN. INTERNAL MED. 1231 (2007); Haider et al., *supra* note 22, at 949 (“[R]ace . . . biases held by physicians are increasingly recognized as potential factors contributing to disparities in health care.”); Padela & Punekar, *supra* note 68, at 72 (“Bias is an inevitable force that may manifest through stereotyping patients and plays a role in creating health care disparities.”); Thomas E. Perez, *The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status, in UNEQUAL TREATMENT*, *supra* note 22, at 626, 628, 633, 636–37 (discussing how racial discrimination is subtle yet ongoing); Janice A. Sabin et al., *Physician Implicit Attitudes and Stereotypes About Race and Quality of Medical Care*, 46 MED. CARE 678 (2008); Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618, 618, 623–24 (1999) (discussing how race and sex influence physician recommendations in the treatment of cardiovascular disease); Michelle van Ryn & Steven S. Fu, *Paved With Good Intentions: Do Public Health and Human Service Providers Contribute to Racial/Ethnic Disparities in Health?*, 93 AM. J. PUB. HEALTH 248 (2003); Melba J.T. Vasquez, *Cultural Difference and the Therapeutic Alliance: An Evidence-Based Analysis*, 62 AM. PSYCHOLOGIST 878 (2007); David R. Williams, *Race, Socioeconomic Status, and Health: The Added Effects of Racism and Discrimination*, 896 ANNALS N.Y. ACAD. SCI. 173, 177–80 (1999); David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 PUB. HEALTH REP. 404, 405–07 (2001). See generally UNEQUAL TREATMENT, *supra* note 22.
128. See AM. COLL. OF PHYSICIANS, RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, UPDATED 2010, at 1 (2010).
129. For information on average life expectancies in the United States, see *Life Expectancy*, CDC.GOV, <http://www.cdc.gov/nchs/fastats/lifexpec.htm> (last updated May 16, 2012).
130. See CTRS. FOR DISEASE CONTROL & PREVENTION, HEALTH, UNITED STATES, 2011, at 98 (2012), available at [http://www.cdc.gov/nchs/data/11.pdf](http://www.cdc.gov/nchs/data/hus/11.pdf); MARIAN F. MACDORMAN & T.J. MATHEWS, NAT'L CTR. FOR HEALTH STATISTICS, NCHS DATA BRIEF NO. 9, RECENT TRENDS IN INFANT MORTALITY IN THE UNITED STATES (2008), available at <http://www.cdc.gov/nchs/data/databriefs/db09.htm>.
131. See CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 130, at 108 tbl.22. The life expectancy gap is up to eight years in some states. See Nazleen Bharmal et al., *State-Level Variations in Racial Disparities in Life Expectancy*, 47 HEALTH SERVICES RES. 544, 546–47 (2012).

21 percent higher for blacks than for whites,<sup>132</sup> and the age-adjusted death rate for the black population exceeds that for the white population by 47 percent for stroke (cerebrovascular disease), 30 percent for heart disease, 20 percent for cancer (malignant neoplasms), 106 percent for diabetes, and 800 percent for HIV.<sup>133</sup> Researchers found that closing the black–white mortality gap would avoid an astonishing “83,000 excess deaths per year among African Americans.”<sup>134</sup>

According to the Centers for Disease Control and Prevention, the rate of high blood pressure for blacks is nearly double that of whites;<sup>135</sup> blacks, Hispanics, and American Indians have higher rates of HIV infection than whites, while Asians have the lowest rates of infection;<sup>136</sup> and diabetes is more prevalent among blacks and Mexican Americans than whites.<sup>137</sup> Race-based disparities in health outcomes are manifest across all areas of medical care and healthcare contexts.<sup>138</sup>

Although many factors contribute to creating and sustaining these widespread health disparities, including social and economic influences, studies have found that implicit bias, discrimination, and stereotyping by physicians play a significant role in producing the health differentials that cleave along racial lines.<sup>139</sup> Evidence shows that race has a significant independent effect on physicians’ perceptions of patients. For example, a 2011 Johns Hopkins study revealed that 69 percent of medical students surveyed exhibited implicit preferences for white people.<sup>140</sup> Other studies have found that physicians tend to rate African American patients more negatively than whites on a number of registers, including intelligence, compliance, and propensity to engage in high-risk health behaviors.<sup>141</sup>

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132. See CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 130, at 110 tbl.23.

133. See *id.* at 113 tbl.24.

134. David Satcher et al., *What if We Were Equal? A Comparison of Black–White Mortality Gap in 1960 and 2000*, 24 HEALTH AFF. 459, 459 (2005).

135. See CTRS. FOR DISEASE CONTROL & PREVENTION, HYPERTENSION AMONG ADULTS IN THE UNITED STATES, 2009–2010 (2012), available at <http://www.cdc.gov/nchs/data/databriefs/db107.htm>.

136. CTRS. FOR DISEASE CONTROL & PREVENTION, HIV SURVEILLANCE REPORT, 2010, at 7 (2012), available at [http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/pdf/2010\\_HIV\\_Surveillance\\_Report\\_vol\\_22.pdf](http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/pdf/2010_HIV_Surveillance_Report_vol_22.pdf).

137. CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 130, at 188 tbl.50.

138. See SARA ROSENBAUM ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 115 (2d ed. 2012); Padela & Punekar, *supra* note 68, at 69.

139. See Padela et al., *supra* note 3, at 465; Vasquez, *supra* note 127, at 875–85. See generally UNEQUAL TREATMENT, *supra* note 22.

140. Haider et al., *supra* note 22, at 949.

141. van Ryn & Burke, *supra* note 106, at 821. Interestingly, these justifications were used to rationalize the Tuskegee syphilis study. See SMITH, *supra* note 2, at 25–26.

Physicians may convey their negative attitudes to minority patients through nonverbal cues and verbal tones or inflections,<sup>142</sup> which may deter some patients from seeking care or complying with medical regimens.<sup>143</sup> These negative attitudes may also shape a patient's experience of a clinical encounter with a physician. Several broad-based studies have found that minority patients perceive less respect in race-disconcordant relationships with physicians,<sup>144</sup> that black Americans were almost twice as likely as their white counterparts (16 percent versus 9 percent) to report being treated with disrespect by a racially disconcordant physician,<sup>145</sup> and that 15 percent of black Americans surveyed believed that they would receive better care if they were of a different race or ethnicity.<sup>146</sup> Further, African American, Hispanic, and Asian patients in race-disconcordant relationships report difficulties communicating with physicians at substantially higher rates than white patients in race-disconcordant relationships.<sup>147</sup>

Researchers have also found that bias in interpersonal aspects of the physician-patient relationship, whether conscious or unconscious, may influence physicians' clinical decisionmaking and may negatively affect treatment recommendations, including the quality and type of care administered to minority patients.<sup>148</sup> In one study published in the *New England Journal of Medicine*, a group of physicians were shown a series of randomly assigned videos. Each depicted an actor portraying a patient and describing symptoms suggestive of cardiovascular disease. All patients were dressed identically, had identical health insurance, described their

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142. van Ryn & Fu, *supra* note 127, at 251.

143. See Malat & Hamilton, *supra* note 20, at 173 (arguing that receiving care from same-race providers is one possible strategy for avoiding interpersonal discrimination in healthcare). African Americans and other ethnic minority patients in race-disconcordant relationships with their physicians report less involvement in medical decisions, less partnership with physicians, lower levels of trust in physicians, and lower levels of satisfaction with care. See Cooper et al., *supra* note 20, at 907; Lisa Cooper-Patrick et al., *Race, Gender, and Partnership in the Patient-Physician Relationship*, 282 J. AM. MED. ASS'N 583 (1999); Somnath Saha et al., *Patient-Physician Racial Concordance and the Perceived Quality and Use of Health Care*, 159 ARCHIVES INTERNAL MED. 997, 998 (1999).

144. See KAREN SCOTT COLLINS ET AL., DIVERSE COMMUNITIES, COMMON CONCERNS: ASSESSING HEALTH CARE QUALITY FOR MINORITY AMERICANS: FINDINGS FROM THE COMMONWEALTH FUND 2001 HEALTH CARE QUALITY SURVEY, at viii (2002); Cooper et al., *supra* note 20, at 912; Jennifer Malat, *Social Distance and Patients' Rating of Healthcare Providers*, 42 J. HEALTH & SOC. BEHAV. 360, 365-66 (2001).

145. COLLINS ET AL., *supra* note 144, at 18, 21.

146. *Id.*

147. See *id.* at 9-10, 13; see also Cooper-Patrick et al., *supra* note 143, at 586 (documenting racial disparities in doctor-patient communications); Elizabeth M. Hooper et al., *Patient Characteristics That Influence Physician Behavior*, 20 MED. CARE 630, 633 (1982).

148. See Green et al., *supra* note 127, at 1235; Sabin et al., *supra* note 127; van Ryn & Burke, *supra* note 106, at 823; van Ryn & Fu, *supra* note 127; David R. Williams & Toni D. Rucker, *Understanding and Addressing Racial Disparities in Health Care*, 21 HEALTH CARE FINANCING REV. 75, 79 (2000).



symptoms in identical terms, and presented identical diagnostic tests. Race and sex were their only distinguishing characteristics. The study found that diagnosis and treatment recommendations varied according to race and sex and that black women were least likely to be referred for diagnostic testing and treatment.<sup>149</sup>

Further, a broad-based, national study conducted in 2003 by the Institute of Medicine (IOM), at the request of Congress, revealed that racial and ethnic minorities receive inferior care compared with nonminorities across a spectrum of diseases, including cancer, cardiovascular disease, HIV/AIDS, diabetes, mental health, and other chronic and infectious diseases.<sup>150</sup> These treatment disparities persisted even when access-related factors, such as insurance status and income, were controlled, and even when preferences and clinical factors were considered, including state of disease presentation, comorbidities, age, and severity of disease.<sup>151</sup> Subsequent research has supported the IOM's conclusions.<sup>152</sup> Other studies have found that racial and ethnic minorities are less likely to undergo bypass surgery or to receive kidney dialysis or transplants, and are more likely to undergo less desirable procedures, such as lower limb amputations for diabetes.<sup>153</sup> Further, physicians in hospital emergency departments prescribe fewer analgesics for black and Latino patients despite similar estimates of pain among groups.<sup>154</sup> Plus, among

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149. See Schulman et al., *supra* note 127, at 623.

150. UNEQUAL TREATMENT, *supra* note 22, at 38–71. The IOM defined disparities as “racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.” *Id.* at 32 (footnote omitted).

151. *Id.* at 32.

152. See, e.g., Jerry Cromwell et al., *Race/Ethnic Disparities in Utilization of Lifesaving Technologies by Medicare Ischemic Heart Disease Beneficiaries*, 43 MED. CARE 330, 334 (2005); Peter W. Groeneveld et al., *Technology Diffusions, Hospital Variation, and Racial Disparities Among Elderly Medicare Beneficiaries 1989–2000*, 43 MED. CARE 320, 323–26 (2005); James M. Guwani & Robert Weech-Maldonado, *Medicaid Management Care and Racial Disparities in AIDS Treatment*, 26 HEALTH CARE FINANCING REV. 119, 128 (2004).

153. See generally Darrell J. Gaskin & Catherine Hoffman, *Racial and Ethnic Differences in Preventable Hospitalizations Across 10 States*, 57 MED. CARE RES. & REV., supp. 1, 2000, at 85; Robert M. Mayberry et al., *Racial and Ethnic Differences in Access to Medical Care*, 57 MED. CARE RES. & REV., supp. 1, 2000 at 108, 129–30; Schulman et al., *supra* note 127; Knox H. Todd et al., *Ethnicity and Analgesic Practice*, 35 ANNALS EMERGENCY MED. 11 (2000) [hereinafter Todd et al., *Ethnicity and Analgesic Practice*]; Knox H. Todd et al., *Ethnicity as Risk Factor for Inadequate Emergency Department Analgesia*, 269 J. AM. MED. ASS'N 1537 (1993) [hereinafter Todd et al., *Ethnicity as Risk Factor*].

154. See Vence L. Bonham, *Race, Ethnicity, and Pain Treatment: Striving to Understand the Causes and Solutions to the Disparities in Pain Treatment*, 29 J.L. MED. & ETHICS 52, 52 (2001) (citing “[n]umerous studies [that] have revealed that racial and ethnic minority groups often receive different and less optimal management of their health care than white Americans” and finding such disparities to be “the legacy of a racially divided health system”); Joshua H. Tamayo-Sarver et al., *Racial and Ethnic*

trauma patients, race is independently associated with higher mortality.<sup>155</sup>

The data thus shows that medical practice remains rife with racial bias and that minority patients often receive substandard healthcare because of physician prejudice. Meanwhile, respecting patients' requests for physician–patient race concordance offers significant benefits, particularly for racial minority patients, including greater patient satisfaction, increased access to preventative care, more effective physician–patient communication, and more participatory decisionmaking, which are all necessary aspects of effective medical treatment.<sup>156</sup> Therefore, accommodating patients' racial preferences may constitute an effective means of countering the effects of physician bias while satisfying Title VI's aim of ensuring that all patients are able to participate in and benefit from federally funded hospitals.

Title VI adopts the strict scrutiny standard of review, according to which the covered entity must prove that its action serves a compelling governmental interest and is essential to achieving that interest (that is, the least restrictive means of realizing that interest).<sup>157</sup> Although this is a high bar, improving patient care, countering racial bias, reducing race-based health disparities, and saving lives should qualify as a compelling interest that justifies bowing to patients' racial preferences. Moreover, the practice of accommodating patients' choices furthers compelling interests in improving healthcare and is narrowly tailored to achieve this interest to the extent that it applies only to those patients who are resolute in their decisions to forego necessary care if their preferences are not accommodated.

#### IV. HOW TO THINK ABOUT THE ACCOMMODATION OF PATIENTS' RACIAL PREFERENCES

Accommodating patients' racial preferences with respect to their choice of physician is an important and enduring practice in the hospital context. Part II demonstrated that EMTALA, along with deeply rooted norms of informed consent and battery, makes clear that there are valid reasons to accommodate. I have also shown that existing antidiscrimination law does not prohibit the practice. As I describe in this Part, however, there are also troubling aspects of indulging patients'

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*Disparities in Emergency Department Analgesic Prescription*, 93 AM. J. PUB. HEALTH 2067 (2003); Todd et al., *Ethnicity as Risk Factor*, *supra* note 153; Todd et al., *Ethnicity and Analgesic Practice*, *supra* note 153.

155. See Adil H. Haider et al., *Race and Insurance Status as Risk Factors for Trauma Mortality*, 143 ARCHIVES SURGERY 945 (2008).

156. See *infra* Part IV.A.

157. See *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265, 305 (1978).

racial biases. Thus, we are faced with the fundamental dilemma of how to reconcile these troubling aspects with respect for patient autonomy and the empirical reality that accommodating patients' racial preferences appears to foster positive health outcomes.

This Part engages this dilemma. Building on the empirical evidence introduced in Part III, this Part makes an affirmative case for accommodating patients' racial preferences with respect to their choice of physician but acknowledges that there are also disadvantages to indulging such requests. This Part addresses the disturbing facets of this practice and concludes by proposing policy solutions designed to alleviate the need for accommodation.

#### A. The Case for Accommodation and Its Limitations

The case for accommodation can be understood to rest on several core empirical insights, including research showing that patients whose racial preferences are respected regarding their choice of physician show higher levels of satisfaction in their clinical encounters and that for some patients having a physician of the same racial background confers substantial health benefits.<sup>158</sup> Indeed, several recent studies on the health benefits of physician–patient race concordance show that such concordance is associated with higher levels of patient-centered communication.<sup>159</sup> And even after adjusting for patient age, gender, education, marital status, health status, and the length of the physician–patient relationship, researchers have found that race-concordant physician–patient relationships tend to promote more participatory decisionmaking.<sup>160</sup>

One study found that race-concordant healthcare visits are longer than discordant visits, and this held true even when researchers accounted for criteria associated with longer patient visits, such as older age, higher socioeconomic status, and inferior health status.<sup>161</sup> The duration of a patient's visit with a provider is considered an important indicator of the quality of care,<sup>162</sup> and patients report that during these longer visits they experience greater ease discussing problems and

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158. See Cooper et al., *supra* note 20, at 913 tbl.3; LaVeist et al., *supra* note 106, at 146; van Ryn & Burke, *supra* note 106, at 823. *But see* Meghani et al., *supra* note 22 (arguing that the results of race-concordance studies are inconclusive).

159. See Cooper et al., *supra* note 20, at 911.

160. Cooper-Patrick et al., *supra* note 143, at 586–87; see Cooper et al., *supra* note 20, at 910.

161. See Cooper et al., *supra* note 20, at 911.

162. See John H. Wiggers & Rob Sanson-Fisher, *Duration of General Practice Consultations: Association With Patient Occupational and Educational Status*, 44 SOC. SCI. MED. 925, 926 (1997).

making decisions.<sup>163</sup> Notably, black patients in a racially concordant relationship with their physicians are more likely to view their healthcare visits as highly participatory, to be more satisfied with their treatment, and to receive preventive care and necessary medical interventions.<sup>164</sup>

In a different study, nearly one-quarter of African Americans and one-third of Latinos reported a preference for same-race healthcare providers,<sup>165</sup> and most chose racially concordant physicians because of personal preferences not solely because of reasons of geographic accessibility.<sup>166</sup> Studies suggest that for these patients physician–patient race concordance not only affects the quality of the interactions but can also improve health outcomes.<sup>167</sup>

In addition to these research findings, EMTALA, medical ethics principles, and the doctrines of informed consent and battery are consistent with the accommodation of patients' racial preferences even if they do not require it. Furthermore, as I have argued, the patchwork of civil rights laws that address race discrimination cannot be read to bar this practice.<sup>168</sup>

Under these circumstances, in order to advance antidiscrimination norms meaningfully—in substance rather than just in form—I argue that we should conceptualize the issue of accommodating patients' racial preferences not in terms of the rigid application of formal antidiscrimination principles but rather through an antisubordination lens. By this I mean that we should address the negative impact that centuries of race discrimination have had on members of disadvantaged groups by allowing for the consideration of race in some circumstances rather than adopt a formalist approach that would view any consideration of race as problematic.<sup>169</sup>

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163. See J.G.R. Howie et al., *Long to Short Consultation Ratio: A Proxy Measure of Quality of Care for General Practice*, 41 BRIT. J. GEN. PRAC. 48, 48 (1991); D.C. Morrell et al., *The "Five Minute" Consultation: Effect of Time Constraint on Clinical Content and Patient Satisfaction*, 292 BRIT. MED. J. 870, 872 (1986).

164. See Jersey Chen et al., *Racial Differences in the Use of Cardiac Catheterization After Acute Myocardial Infarction*, 344 NEW ENG. J. MED. 1443, 1447–48 (2001); Saha et al., *supra* note 143, at 998.

165. See Padela & Punekar, *supra* note 68, at 69.

166. See Saha et al., *supra* note 21, at 76–83.

167. See *supra* Part III.C.

168. See *supra* Part II.

169. Several constitutional law scholars conceptualize the role of race in government decisionmaking as cleaving according to the anticlassification and antisubordination interests. See, e.g., Jack M. Balkin & Reva B. Siegel, *The American Civil Rights Tradition: Anticlassification or Antisubordination?*, 58 U. MIAMI L. REV. 9, 9 (2003) (attributing the antisubordination idea to Owen Fiss and explaining that “[a]ntisubordination theorists contend that guarantees of equal citizenship cannot be realized under conditions of pervasive social stratification and argue that law should reform institutions and practices that enforce the secondary social status of historically oppressed groups”); Charles R. Lawrence III, *Forbidden Conversations: On Race, Privacy, and Community (A Continuing Conversation With John Ely on Racism and Democracy)*, 114 YALE L.J. 1353, 1382 (2004) (asserting that the Equal Protection

As noted in Part II, EMTALA and the modern doctrines of battery and informed consent emerged in part to protect poor and racial-minority patients from patient dumping, nonconsensual treatment, and battery in medical practice and clinical research. Prohibiting the accommodation of patients' racial preferences in light of recent evidence of pervasive physician bias may, ironically, jeopardize the health of racial minority patients by rendering them vulnerable to the kinds of abuses against which these laws and legal doctrines were established to guard.

### B. The Limits of Accommodation

Although the accommodation of patients' racial preferences appears to confer significant benefits to patients of all races,<sup>170</sup> we may still be troubled by the difficulty of distinguishing between legitimate expressions of racial preference for physician race concordance and those based in racism or bigotry. Undoubtedly, there are many reasons why patients may request or decline treatment by physicians of a particular racial or ethnic background. These reasons include positive prior experiences in racially concordant relationships, negative past experiences with physician bias in racially discordant relationship, and racism—namely, bigotry or prejudices about members of certain racial and ethnic groups other than one's own.

Patients who have had positive experiences with people of the same racial or cultural background may be more trusting of and feel more comfortable with physicians who share their racial or cultural characteristics.<sup>171</sup> This sense of sharing a common culture or social experience may also lead patients to believe (rightly or wrongly) that a physician of a similar racial group is more likely to promote and protect their interests and to exercise more sensitive care with regard to treatment.<sup>172</sup>

Negative experiences may also drive a patient toward rejecting or requesting a physician of a particular racial background, as preferences may be shaped by lingering distrust resulting from one's own or others' prior experiences of racial bias,

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Clause "creates a new substantive value of 'non-slavery' and antisubordination to replace the old values of slavery and white supremacy"); Reva B. Siegel, *Equality Talk: Antisubordination and Anticlassification Values in Constitutional Struggles Over Brown*, 117 HARV. L. REV. 1470, 1472–73 (2003) (describing the antisubordination principle as "the conviction that it is wrong for the state to engage in practices that enforce the inferior social status of historically oppressed groups").

170. See generally Cooper et al., *supra* note 20, at 907; Cooper-Patrick et al., *supra* note 143; LaVeist & Nuru-Jeter, *supra* note 22.

171. See generally David H. Thom, *Physician Behaviors That Predict Patient Trust*, 50 J. FAM. PRAC. 323 (2001).

172. See LaVeist & Nuru-Jeter, *supra* note 22, at 303; Malat & Hamilton, *supra* note 20, at 174.

discrimination, or discourteous or substandard care.<sup>173</sup> While segregation and blatant racial discrimination are no longer the norm in medicine, numerous studies report that more subtle forms of discrimination endure.<sup>174</sup> Although most patients are sensitive to the interpersonal dynamic that occurs in medical encounters, black patients may be acutely aware of interpersonal cues from physicians because of historical and personal experiences with discrimination in healthcare and in society at large.<sup>175</sup> Research on racial stigma suggests that individuals cope with the threat of bias or discrimination by avoiding interactions with the stigmatizing group.<sup>176</sup> Thus, to avoid negative encounters, racial minorities (who are more likely to experience discrimination while seeking health services) may prefer physician–patient racial concordance or reject physicians who are members of a perceived stigmatizing group.<sup>177</sup>

Finally, a patient's request for or refusal of treatment by a physician of a particular race may also be a manifestation of racism.<sup>178</sup> For example, during the period of legally sanctioned segregation, many white professionals and the lay public openly expressed the belief that the medical care provided by black physicians was necessarily of poor quality.<sup>179</sup>

The source of patients' racial preferences with respect to their choice of physicians should play a part in determining appropriate policy solutions. Standard

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173. See Vanessa Northington Gamble, *Under the Shadow of Tuskegee: African Americans and Health Care*, 87 AM. J. PUB. HEALTH 1773, 1776 (1997) (arguing that black Americans' distrust of the medical profession is rooted in a long history of exploitation and disrespect, epitomized by the Tuskegee study, whose legacy "endures, in part, because the racism and disrespect for [b]lack lives that it entailed mirror [b]lack people's contemporary experiences with the medical profession").
  174. See Calman, *supra* note 127, at 172–74 (explaining how racial prejudices affect and limit patients' health care opportunities); Perez, *supra* note 127, at 628, 633, 636–37; Schulman et al., *supra* note 127, at 618, 623–24 (discussing how race and sex influence physician recommendations in the treatment of cardiovascular disease); Todd et al., *Ethnicity and Analgesic Practice*, *supra* note 153; Todd et al., *Ethnicity as Risk Factor*, *supra* note 153; van Ryn & Burke, *supra* note 106 (finding that doctors' opinions regarding their African American patients tend to be more negative than those regarding their white patients); Williams, *supra* note 127, at 177–80; Williams & Collins, *supra* note 127, at 405–07.
  175. See Cooper et al., *supra* note 20, at 913; LaVeist et al., *supra* note 106, at 151; van Ryn & Burke, *supra* note 106.
  176. See Alvin N. Alvarez & Linda P. Juang, *Filipino Americans and Racism: A Multiple Mediation Model of Coping*, 57 J. COUNSELING PSYCHOL. 167 (2010); Elizabeth Brondolo et al., *Coping With Racism: A Selective Review of the Literature and a Theoretical and Methodological Critique*, 32 J. BEHAV. MED. 64 (2009); Vetta L. Sanders Thompson, *Coping Responses and the Experience of Discrimination*, 36 J. APPLIED SOC. PSYCHOL. 1198 (2006).
  177. See COLLINSET AL., *supra* note 144, at 18, 21.
  178. LaVeist & Nuru-Jeter, *supra* note 22, at 303 ("[R]ace concordant patient preference may be a manifestation of the internalization of broader societal racism.").
  179. See BYRD & CLAYTON, *supra* note 1, at 65.

medical practice requires those who express these preferences to undergo an ethics consultation to determine not only the strength of their conviction but also to impress on the patient the advantages of working with the assigned physician.<sup>180</sup> Yet in a life-threatening situation or when the patient has no alternate venue for medical care, is firm in her decision, and cannot be deterred; EMTALA, battery, and medical ethics rules counsel that the patient's preferences be respected.

Still, the notion of white patients rejecting minority physicians for bigoted reasons in emergency departments and other hospital settings is deeply troubling and uncomfortably reminiscent of the type of discrimination that the civil rights statutes were designed to eliminate. This concern complicates emergency department physicians' duty to provide necessary treatment and their efforts to uphold their promise under the Hippocratic Oath to do no harm. It also underscores a fundamental tension between their roles as healers and as conservators of widely shared moral precepts.<sup>181</sup>

The reality, however, is that this problem may seldom arise, as a recent study found that requests for treatment by a physician of a particular race are most often accommodated when made by racial minority patients.<sup>182</sup> This practice may be

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180. See Padela & Punekar, *supra* note 68, at 71.

181. Under the *AMA Code of Ethics*, physicians have "ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare." Opinion 10.015, *supra* note 109.

182. See Padela et al., *supra* note 3, at 468. Moreover, white physicians account for approximately 78.4 percent of emergency physicians in the United States. ASS'N OF AM. MED. COLLS., DIVERSITY IN THE PHYSICIAN WORKFORCE: FACTS AND FIGURES 2010, at 75 tbl.9 (2010), available at [https://members.aamc.org/eweb/upload/Diversity in the Physician Workforce Facts and Figures 2010.pdf](https://members.aamc.org/eweb/upload/Diversity%20in%20the%20Physician%20Workforce%20Facts%20and%20Figures%202010.pdf).

Therefore, white patients who seek a physician of the same race tend to have little difficulty locating one. See Benton, *supra* note 3, at 23; *Total Physicians by Race/Ethnicity—2008*, AM. MED. ASSOC., <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/minority-affairs-section/physician-statistics/total-physicians-raceethnicity.page> (last visited Nov. 17, 2012). This is not the case for racial and ethnic minority populations, which are twice as likely as whites to rely on physicians in emergency departments, hospital clinics, or outpatient departments for their regular care rather than on a private physician or other office-based provider. See Padela & Punekar, *supra* note 68, at 69 (finding that the emergency department is often the primary venue for underserved ethnic and racial minorities to access healthcare); see also ROSENBAUM ET AL., *supra* note 138, at 115; Marsha Lillie-Blanton & Caya B. Lewis, *Policy Challenges and Opportunities in Closing the Racial/Ethnic Divide in Health Care* 3 (Kaiser Family Found. Issue Brief, 2005) ("28% of Latinos and 22% of African Americans report having little or no choice in where to seek care, while only 15% of whites report this difficulty."). Research shows that people of color have less access to healthcare when compared to whites, as the level of uninsurance is 34 percent among Hispanics and 21 percent among blacks versus 13 percent among whites. Nicole Lurie & Tamara Dubowitz, *Health Disparities and Access to Health*, 297 J. AM. MED. ASS'N 1118, 119 (2007). Moreover, minority women are more likely to avoid a visit to a physician for financial reasons. CARA V. JAMES ET AL., KAISER FAMILY FOUND., PUTTING WOMEN'S HEALTH CARE DISPARITIES ON THE MAP: EXAMINING RACIAL AND ETHNIC DISPARITIES AT THE STATE LEVEL 56 (2009). Further,

justified to the extent that racial and ethnic minority patients are statistically more likely than white patients to experience discriminatory treatment in a racially discordant physician–patient encounter.<sup>183</sup> Moreover, the chance of experiencing such discriminatory treatment is heightened in the hospital environment, which is “ripe for misunderstandings, stereotyping, and poor collaboration,” as physicians who work in hospital emergency departments are often fatigued and must operate under significant time constraints.<sup>184</sup> Research indicates that individuals often rely on unconscious biases and stereotyping in such circumstances as these cognitive processes allow individuals to evaluate complex information quickly through the use of social categories.<sup>185</sup> The negative consequences of this behavior are likely to have a disproportionate effect on blacks and Latinos.

None of this is to suggest that we should not remain concerned about racist motives among patients. Nevertheless, substantial empirical data attests to the medical significance and benefits of accommodating patients' racial preferences, and to the extent that evidence shows unequivocally that it improves health outcomes and may contribute to the reduction of race-based health disparities, then we should respect patients' racial preferences in the hospital context.

### C. Beyond Accommodation

As this Article demonstrates, there are immense benefits to accommodating patients' racial preferences in the hospital setting, including improving the quality

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“Native Americans and Native Alaskans more often lack prenatal care in the first trimester.” AM. COLL. OF PHYSICIANS, *supra* note 128, at 3. And although demand for emergency services rose to 136 million total visits in 2009, African Americans visited at a greater rate than whites. *See* Brown, *supra* note 34.

183. *See* COLLINS ET AL., *supra* note 144, at 18, 21.

184. Padela & Punekar, *supra* note 68, at 71; *see* UNEQUAL TREATMENT, *supra* note 22, at 199–214; Fred G.W.C. Paas & Jeroen J.G. Van Merriënboer, *Instructional Control of Cognitive Load in the Training of Complex Cognitive Tasks*, 6 EDUC. PSYCHOL. REV. 351 (1994).

185. *See* Haider et al., *supra* note 22, at 949; *see also* John A. Bargh et al., *Automaticity of Social Behavior: Direct Effects of Trait Construct and Stereotype Activation on Action*, 71 J. PERSONALITY & SOC. PSYCHOL. 230, 239 (1996) (explaining that individuals placed in a frustrating situation responded with more hostility when subliminally primed using an African American male face than a white male face); Paul Brest, *Foreword: In Defense of the Antidiscrimination Principle*, 90 HARV. L. REV. 1, 8 (1976) (addressing the ways in which people tend to favor in-group members and their interests more than out-group members); Barbara J. Flagg, *“Was Blind, but Now I See”: White Race Consciousness and the Requirement of Discriminatory Intent*, 91 MICH. L. REV. 953, 959 (1992) (“The imposition of transparently white norms is a unique form of unconscious discrimination . . .”); Charles R. Lawrence III, *The Id, the Ego, and Equal Protection: Reckoning With Unconscious Racism*, 39 STAN. L. REV. 317, 322 (1987) (arguing that in American culture and society racism permeates virtually everyone's unconscious).



of care provided to minority populations and addressing racial and ethnic health differentials. Nevertheless, this Article has shown that this practice is not without its limitations, as it offers neither a complete nor a fully satisfying solution to the problems of race-based health disparities and physician bias. To devise appropriate, long-term means of addressing these concerns, the medical profession must go beyond accommodating patients' racial preferences to expanding cultural awareness at all levels of practice and training to enable providers to interact more effectively with various patient populations. The profession must also increase diversity among providers as a means of encouraging tolerance and understanding of other cultures.<sup>186</sup>

In order to train physicians to better comprehend and address the specific needs of a diverse patient population, in recent years, the medical profession and medical schools have focused on providing culturally competent care, which, according to the IOM, requires the provision of care "that is respectful of and responsive to individual patient preferences, needs, and values."<sup>187</sup> The idea behind culturally competent care is the promotion of greater "physician understanding of social, cultural, and economic factors that influence their patients," and the fostering of an effective patient-physician relationship.<sup>188</sup> Thus, the American College of Physicians, the largest medical specialty society in the United States, recommends that "[p]hysicians and other health care professionals must be sensitive to cultural diversity among patients and recognize that preconceived perceptions of minority patients may play a role in their treatment and contribute to disparities in health care among racial and ethnic minorities."<sup>189</sup>

Cultural-competency training is necessary at all levels of medical education and professional practice, as a 2011 Johns Hopkins study found that medical students may actually learn to treat nonwhite patients differently from white patients.<sup>190</sup> While survey data shows that virtually all medical residents recognize the importance of addressing cultural-competency issues, nearly one in five believes that they were ill prepared to care for individuals who did not share their Anglo-American

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186. See Padela & Punekar, *supra* note 68, at 69; see also Chen et al., *supra* note 21.

187. COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 6 (2001).

188. Jeremy Spevick, *The Case for Racial Concordance Between Patients and Physicians*, AM. MED. ASS'N J. ETHICS VIRTUAL MENTOR, June 2003, <http://virtualmentor.ama-assn.org/2003/06/jdsc2-0306.html> (citing Amici Curiae Brief of the Association of American Medical Colleges et al. in Support of the State of Texas, Seeking Rehearing En Banc and Reversal at 9, *Hopwood v. Texas*, 236 F.3d 256 (5th Cir. 2000) (No. 98-50506)).

189. AM. COLL. OF PHYSICIANS, *supra* note 128, at 1; see also UNEQUAL TREATMENT, *supra* note 22, at 199-214 (describing the body of literature in support of cross-cultural education in the training of physicians).

190. See Haider et al., *supra* note 22, at 949.

cultural beliefs regarding the practice of medicine.<sup>191</sup> Many medical residents also report that they lack professional mentorship in the area of cross-cultural care and are seldom evaluated on their cultural-competency skills.<sup>192</sup>

Therefore, although cultural-competency training is critical to fostering trust and communication—two elements necessary to an effective physician–patient relationship—and to improving health outcomes and reducing health disparities, studies make clear that more needs to be done to bridge the gap.<sup>193</sup> Medical schools must also create an environment where students can interact with a racially and ethnically diverse cohort, faculty, and community of mentors because this, as much as textbooks and clinical learning, is a necessary and integral part of a quality medical education and an important means of promoting understanding between future physicians and their prospective patients. Yet, despite the fact that research reveals that students in a diverse student body demonstrate better cultural competency and cross-cultural training than those trained in a more racially and ethnically homogeneous academic environment, of more than 16,000 medical school graduates in 2008, only 2447 were African American, Hispanic, or Native American.<sup>194</sup>

Among the many benefits of a multicultural medical school environment is its potential to increase the racial and ethnic diversity within the ranks of the profession.<sup>195</sup> Members of racial and ethnic minority populations are severely underrepresented in the medical profession. Although African Americans, Hispanics, and Native Americans constitute over 25 percent of the nation's population, in 2007 African Americans accounted for only 3.5 percent, Hispanics 5 percent, and Native Americans and Native Alaskans 0.2 percent of physicians.<sup>196</sup>

A multicultural physician workforce that reflects the country's racial and ethnic diversity and that is more representative of the patients it serves may not only improve patient satisfaction, strengthen cultural competence, and promote sensitivity and tolerance among health professionals; it may also facilitate quality care and reduce physician biases along with the need for the accommodation of patients' racial preferences.

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191. AM. COLL. OF PHYSICIANS, *supra* note 128, at 10–11.

192. *Id.* at 11.

193. Spevick, *supra* note 188; *see also* UNEQUAL TREATMENT, *supra* note 22, at 1.

194. *See* AM. COLL. OF PHYSICIANS, *supra* note 128, at 14.

195. *Id.* at 14.

196. *Id.* at 13.

### CONCLUSION

Despite this country's long and sordid history of race discrimination in healthcare, race remains of significant salience in medicine, and there are ways in which it is still being used that are neither widely discussed nor fully regulated. Although the common, if little debated, practice of physicians acceding to patients' racial preferences in the hospital setting might, at first glance, appear to perpetuate this history of inequality and violate antidiscrimination laws, as this Article makes clear, there are several important reasons why physicians quietly, but routinely, engage in this practice and why antidiscrimination laws have not been and should not be interpreted to reach this conduct.

Numerous studies show that physician-patient race concordance confers tremendous health benefits to patients, particularly those from racial minority populations, and advances antistatutory norms. Therefore, until we improve diversity within medical education and the profession, and unless we effectively educate and train a more culturally competent corps of physicians, we must preserve the practice of accommodating patients' racial preferences in the hospital setting. Indeed, although the kind of discrimination that Juliette Derricotte and John McBride faced is no longer permitted, it may be, ironically, that accommodating patients' own racial preferences within hospitals not only comports with our normative commitments to racial equality but also constitutes one of the most effective means currently available to advance racial justice in healthcare, and, quite possibly, to save patients' lives.