

U.C.L.A. Law Review

***Bakke* at 40: Remediating Black Health Disparities Through Affirmative Action in Medical School Admissions**

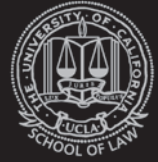
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ABSTRACT

Forty years after the landmark Supreme Court decision in *U.C. Regents v. Bakke*, medical schools remain predominantly white institutions. In *Bakke*, Justice Powell infamously rejected the concept of societal discrimination, which was offered as a justification for the U.C. Davis medical school's race-conscious admissions program, as "an amorphous concept of injury that may be ageless in its reach into the past." In affirming the application of strict scrutiny analysis to policies involving benign racial classifications, the Court ushered in a strict scrutiny regime under which public universities must develop and defend their consideration of race in higher education admissions. With the *Bakke* decision, the Court effectively endorsed a false equivalency between laws intended to subordinate Black people and laws intended to remedy the effects of anti-Black discrimination. Consequently, since 1978 courts and universities have diverted their attention from mitigating the impact of past and present racial discrimination to safeguarding the diversity rationale, which has proven vulnerable to ongoing litigation and faces the possibility of being eliminated entirely with the revamp of the federal courts into a solidly conservative judiciary under President Trump.

As the reality of the end of affirmative action looms, empirically derived justifications for race-conscious remedies pose a direct challenge to the arguments advanced by its most staunch opponents. The persistence of racial disparities in various areas of wellbeing such as education, criminal justice, and health militates against notions of racism as amorphous or an evil of the past. Racial health disparities in particular have recently become the subject of widespread media attention, due in part to the health challenges faced by tennis star Serena Williams during her pregnancy, and related reports highlighting the crisis of maternal mortality which disparately impacts Black women. This crisis in Black maternal health illustrates only part of a broader health crisis facing Black Americans, and compels a closer look at the history of racism within our medical institutions and the medical profession.

In this Comment, I argue that the persistence of racial health disparities today is not only a relic of a long history of anti-Black racism in healthcare, but a consequence of the Court's colorblind approach to affirmative action jurisprudence since *Bakke* and the restrictions in access to predominantly white institutions that have resulted. In recounting the history of racism in medical experimentation and healthcare policy since the antebellum period, this analysis seeks to locate racism in a particular form and illustrate how notions of racism as amorphous—and therefore outside the scope of a constitutional remedy—elide the state's role in perpetuating racial disparities that persist to this day.



In reevaluating the justifications for race-conscious medical school admissions that were ultimately rejected in *Bakke*, this Comment explores the empirical research related to physician racial bias and Black patients' mistrust of the medical institution, and the efficacy of race-concordant healthcare as an intervention. Collectively, the data proffered suggests that there is an interactional racial dynamic that significantly affects medical service delivery, which should inform race-conscious admissions practices in medical schools. Finally, the legal analysis brings both of these strands together by reexamining the Court's seminal affirmative action cases from the past four decades in light of the history and the empirical evidence documented here. The end result makes a compelling case for affirmative action that harkens back to its original intent—to ameliorate the effects of racial discrimination—precisely at a moment where it is on its last legs. It clarifies why affirmative action was always necessary, and why affirmative action must stay.

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Of all the forms of inequality, injustice in health is the most shocking and the most inhuman.¹

—Dr. Martin Luther King Jr.

INTRODUCTION

In early 2017, Shalon Irving, a 36-year-old epidemiologist at the Center for Disease Control, abruptly died from complications of high blood pressure just three weeks after giving birth to her first child.² Shalon's untimely death shocked her family, community, and colleagues, who never expected that the vibrant young woman who had dedicated her medical career to eliminating disparities in health outcomes and access to care could herself fall victim to preventable maternal mortality.³

Black women like Shalon are two to three times more likely than white women to die of common pregnancy and childbirth related causes.⁴ This racial disparity⁵ in health outcomes has endured for decades despite advances in medical technology and treatment. Yet, disparities in maternal mortality rates are only part of a broader problem of racial health inequity in the U.S. healthcare system, a health crisis that has started to receive national media attention in recent years.⁶ In 2012, the cancer death rate for Black men was 24 percent higher

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1. Dr. Martin Luther King Jr. made this statement at a 1966 press conference in Chicago connected with the annual meeting of the Medical Committee for Human Rights. *Dr. Martin Luther King on Health Care Injustice*, PHYSICIANS FOR A NAT'L HEALTH PROGRAM (Oct. 14, 2014), <http://www.pnhp.org/news/2014/october/dr-martin-luther-king-on-health-care-injustice> [https://perma.cc/BAC4-UC48]; see also Amanda Moore, *Tracking Down Martin Luther King, Jr.'s Words on Health Care*, HUFFPOST: THE BLOG (Jan. 18, 2013, 4:00 PM), http://www.huffingtonpost.com/amanda-moore/martin-luther-king-health-care_b_2506393.html [https://perma.cc/5JMX-KDKA].
 2. Nina Martin, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 7, 2017, 7:51 PM), <http://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why>.
 3. *Id.*
 4. *Id.*
 5. A health disparity exists when a health outcome occurs to a greater or lesser extent between different populations, including racial groups. See *Disparities*, HEALTHYPEOPLE.GOV, <http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities> [https://perma.cc/FNH5-3RGE].
 6. See Emily Deruy, *6 Key Health Disparities Between Blacks and Whites*, ATLANTIC (Oct. 8, 2015), <https://www.theatlantic.com/politics/archive/2015/10/6-key-health-disparities-between-blacks-and-whites/433056> [https://perma.cc/JW4E-B4WF]; Jacqueline Howard, *Black Americans Living Longer, but Racial Gap Remains*, CDC Says, CNN (May 2, 2017, 4:13 PM), <http://www.cnn.com/2017/05/02/health/african-american-death-rates-cdc-study/index.html> [https://perma.cc/85K6-SKKL]; Robert Pearl, *Why Health Care Is*

than it was for white men, while the cancer death rate for Black women was 14 percent higher than for white women.⁷ Black children in the United States are more likely to die before their first birthday than children of other racial groups.⁸ Black Americans between the ages of 18 and 49 are nearly twice as likely to die from chronic conditions such as diabetes, stroke, or heart disease as white people in the same age range, due in large part to earlier disease development.⁹

Racial disparities in the utilization of healthcare, health outcomes, and access to quality medical care have been the subject of scientific literature for decades.¹⁰ Academic publications documenting racial health disparities are frequently targeted toward and consumed by practitioners and scholars in the medical and social sciences communities. This limited distribution and consumption is entirely reasonable, given that those professional and academic spheres are the sites where scientific discovery, data analysis and innovations in treatment aimed at preventing disease and improving public health take place. Nonetheless, the scant attention the issue of racial health disparities has received in legal scholarship generally, and in analyses of affirmative action jurisprudence specifically, is cause for concern. When one acknowledges that the law is both a source of racial subordination¹¹ and a main determinant of how patients access

Different if You're Black, Latino or Poor, FORBES (Mar. 5, 2015, 12:59 PM), <http://www.forbes.com/sites/robertpearl/2015/03/05/healthcare-black-latino-poor> [<https://perma.cc/TKS5-BSJ9>]; Ashley Welch, *African-Americans Are Living Longer, but Health Disparities Remain*, CBS NEWS (May 2, 2017, 3:10 PM), <http://www.cbsnews.com/news/african-american-living-longer-health-disparities-remain-cdc-report> [<https://perma.cc/Z5FS-ZXND>].

7. AM. CANCER SOC'Y, CANCER FACTS & FIGURES FOR AFRICAN AMERICANS 2016–2018 1 (2016), <http://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-african-americans/cancer-facts-and-figures-for-african-americans-2016-2018.pdf> [<https://perma.cc/N8RD-UQMW>].
8. *See Infant Mortality*, CDC, <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm> [<https://perma.cc/3L4V-HJFH>].
9. Timothy J. Cunningham et al., *Vital Signs: Racial Disparities in Age-Specific Mortality Among Blacks or African Americans—United States, 1999–2015*, 66 MORBIDITY & MORTALITY WKLY. REP. 444, 447 (2017), <http://www.cdc.gov/mmwr/volumes/66/wr/pdfs/mm6617e1.pdf> [<https://perma.cc/L3K3-FJHL>].
10. At the turn of the century, more than 600 scientific publications documenting racial disparities in healthcare had been produced. In 1999, the U.S. Congress's authorization of the Institute of Medicine Study to analyze racial health disparities drew further attention to magnitude of the issue. *See* W. Michael Byrd & Linda A. Clayton, *Racial and Ethnic Disparities in Healthcare: A Background and History*, in *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 455, 455 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003) [hereinafter Byrd & Clayton, *Disparities*].
11. The historical centrality and complicity of the law in upholding white supremacy is a basic tenet of Critical Race Theory, which provides the theoretical framework for this paper. *See*

healthcare,¹² the plausibility of using the law as a tool to substantially contribute to the elimination of racial health disparities is clear. In discussions of strategies for reducing racial health inequality, however, the significance of law and policy—if referenced at all¹³—is often limited to policy changes around access to care.¹⁴

There is a growing body of research suggesting that the nonwhite racial identity of a medical practitioner positively influences nonwhite patients' healthcare utilization, satisfaction with treatment, and health outcomes. Preliminary studies exploring the role a provider's race may play in the quality of the physician-patient relationship and in health outcomes for minority patients have found that race concordance¹⁵ between providers and patients is linked to increased patient satisfaction,¹⁶ higher medication adherence,¹⁷ and better health outcomes for women.¹⁸ One of the earliest examinations of the correlation between minority health and the race of the attending physician concluded that "[g]iven the under-representation of minorities among the ranks of health care providers . . . minority patients are less likely to be race concordant compared to

Cornel West, *Foreword* to *CRITICAL RACE THEORY: THE KEY WRITINGS THAT FORMED THE MOVEMENT* (Kimberlé Crenshaw et al. eds., 1995).

12. In the U.S. healthcare system, as with most healthcare systems, a consumer purchases a health product or service at a particular price. Regulators and policymakers, particularly within the federal government, govern the healthcare industry. See SARMAD SADEGHI ET AL., *INTEGRATING QUALITY AND STRATEGY IN HEALTH CARE ORGANIZATIONS* 3 (2013).
13. See Mary Anne Bobinski, *Health Disparities and the Law: Wrongs in Search of a Right*, 29 AM. J.L. & MED. 363, 370 (2003) ("Healthy People 2010 makes only occasional reference to the role of law in its discussion of goals, focus areas, leading indicators and objectives. Laws and regulations lurk in the background of discussions on topics such as access to care, environmental health, educational and community-based programs, and tobacco control." (citations omitted)).
14. See *id.* at 371–72.
15. In the medical context, "concordance is most often defined as a similarity, or shared identity, between physician and patient based on a demographic attribute, such as race, sex, or age." Richard L. Street, Jr. et al., *Understanding Concordance in Patient-Physician Relationships: Personal and Ethnic Dimensions of Shared Identity*, 6 ANNALS FAM. MED. 198, 199 (2008).
16. See LISA A. COOPER & NEIL R. POWE, COMMONWEALTH FUND, *DISPARITIES IN PATIENT EXPERIENCES, HEALTH CARE PROCESSES, AND OUTCOMES: THE ROLE OF PATIENT-PROVIDER RACIAL, ETHNIC, AND LANGUAGE CONCORDANCE* vi (2004), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2004_jul_disparities_in_patient_experiences_health_care_processes_and_outcomes_the_role_of_patient_provide_cooper_disparities_in_patient_experiences_753_pdf.pdf [<https://perma.cc/KQ3U-M4KX>].
17. Ana H. Traylor et al., *Adherence to Cardiovascular Disease Medications: Does Patient-Provider Race/Ethnicity and Language Concordance Matter?*, 25 J. GEN. INTERNAL MED. 1172, 1172 (2010).
18. See Marjory Charlot et al., *Impact of Patient and Navigator Race and Language Concordance on Care After Cancer Screening Abnormalities*, 121 CANCER 1477, 1483 (2015).

whites. [This] tendency to underutilize[] health services in the absence of doctor-patient race concordance might therefore exacerbate racial/ethnic disparities in health.”¹⁹ The advocacy of the medical and social sciences communities calling for a more diverse pool of medical practitioners, however, can only go so far. Affirmative action doctrine governs the extent to which race can be considered in admissions in higher education, and medical schools—where attendance is a prerequisite for becoming a licensed medical practitioner²⁰—are not exempt from this governance. To create a healthcare system equipped to remedy the crisis of racial health disparities, then, medical schools face the uphill battle of implementing race-conscious admissions policies, which not only take into account the constraints of affirmative action jurisprudence, but also directly challenge the doctrine’s colorblind theoretical underpinnings. To put it simply, race matters in healthcare, and consensus in the medical community indicating as much should be front and center in the debate over the constitutionality of race-conscious admissions to medical schools.

Although diversifying the medical profession has been cited as a viable strategy to combat underutilization of healthcare by racial minority groups, few legal scholars have explicitly identified remedying racial health disparities as a rationale for affirmative action in medical schools.²¹ The persistence of racial health disparities over the last four decades on one hand, and the decline in enrollment of nonwhite students in public medical schools due to affirmative action bans in six states—including California—on the other hand hint at the two-dimensional nature of racial disparities: Racial disparities in health outcomes and the existence of racial inequity in access to the medical education needed to improve those outcomes are related. That Black patients continue to suffer from preventable and treatable illnesses as aspiring Black doctors contend with institutional barriers to medical school enrollment raises the question—

19. Thomas A. LaVeist, Amani Nuru-Jeter & Kiesha E. Jones, *The Association of Doctor-Patient Race Concordance with Health Services Utilization*, 24 J. PUB. HEALTH POL’Y 312, 320 (2003).

20. See *The Road to Becoming a Doctor*, AAMC, <http://www.aamc.org/download/68806/data/road-doctor.pdf> [<https://perma.cc/N3SR-3FXB>].

21. Notably, a few legal scholars have engaged with the idea that remedying racial health disparities should be a compelling state interest justifying affirmative action programs in health professions schools. See Lisa C. Ikemoto, *Racial Disparities in Health Care and Cultural Competency*, 48 ST. LOUIS U. L.J. 75, 125 (2003); Thomas E. Perez, *Enhancing Access to Health Care and Eliminating Racial and Ethnic Disparities in Health Status: A Compelling Case for Health Professions Schools to Implement Race-Conscious Admissions Policies*, 9 J. HEALTH CARE L. & POL’Y 77, 78–80 (2006); see also Brief Amici Curiae of the National Coalition of Blacks for Reparations in America (N’COBRA) and the National Conference of Black Lawyers (NCBL) in Support of Respondents, *Grutter v. Bollinger*, 539 U.S. 306 (2003) (No. 02-241) and *Gratz v. Bollinger*, 539 U.S. 244 (2003) (No. 02-516), 2003 WL 400443.

what precisely is the relationship between racial disparities and racial inequity in access to the professional training necessary to help remedy those disparities?

The fortieth anniversary of *U.C. Regents v. Bakke*²² warrants further exploration of this nexus not only in the context of healthcare, but also in our broader understanding of racial inequality and its relationship to race-conscious remediation. In *Bakke*, Justice Powell infamously rejected the concept of societal discrimination as a justification for race-conscious admissions in a state medical school as “an amorphous concept of injury that may be ageless in its reach into the past,” in favor of the diversity rationale—the notion that attainment of a diverse student body produces a learning atmosphere that benefits from a broad range of viewpoints.²³ Consequently, since 1978 courts and universities have diverted their attention from addressing racial discrimination to focusing on what Derrick Bell has described as “diversity’s distractions.”²⁴ The persistence of racial disparities, however, militates against the claim that societal discrimination is amorphous. In stark contrast, racial disparities illustrate how specific policies, practices, and institutions have historically discriminated against racially subordinated groups, and expose the tangible consequences of how failure to take account of such race-based harms via race-based remedies reinforces that disadvantage. This Comment seeks to demonstrate that while societal discrimination in the context of affirmative action has historically been understood as too amorphous of a concept for the Court to entertain, an investigation into how specific policies, practices, and institutions have caused explicit race-based harms locates racism in a particular form, and compels the Court to recognize the necessity of a corresponding race-based remedy.

In examining the remedial function that affirmative action in medical school admissions can serve to reduce Black health disparities,²⁵ and in analyzing the constitutionality of race-conscious admissions programs designed accordingly, I embark upon a historicized recasting of the relationship between racial disparities and race-conscious remedies to illustrate how the evisceration of racial remediation in the four decades since *Bakke* has done much more than perpetuate racial inequity in access to higher education. It’s made Black access to healthcare more difficult to come by. Legally imposed barriers to educational access reinforce tangible racial injustices in Black people’s everyday lives. I

22. 438 U.S. 265 (1978).

23. *Id.* at 307.

24. See generally Derrick Bell, *Diversity’s Distractions*, 103 COLUM. L. REV. 1622 (2003).

25. The author fully acknowledges that many nonwhite racial groups experience racial and ethnic health disparities but elects to focus solely on Black health disparities and their unique historical context in this Comment.

expand on the notion that tragedies like the death of Shalon Irving could be prevented by taking account of racism in healthcare delivery by suggesting that a critical component of achieving that goal is taking account of race in medical school admissions.

Part I of this Comment explores the history of anti-Black racism in U.S. healthcare, from experimentation on Black bodies during the antebellum period to the anti-Black sentiment underlying states' decisions to opt out of the Medicaid expansion permitted by the Affordable Care Act. This historical overview illustrates the role of the state in creating the very circumstances that have resulted in persistent racial health disparities and perpetuated poor health outcomes for Black individuals vis-à-vis neglectful policy decisions, illustrating the core Critical Race Theory claim that "[o]ur racial past exerts contemporary effects."²⁶

Part II relies on scientific literature in making the case that more Black doctors could significantly improve Black health. It examines the salience of race in the context of healthcare delivery, as exemplified by the growing amount of data on physician racial bias and the deeply rooted mistrust that impacts Black patients' experiences with medical treatment. I review the substantial social science literature published post-*Bakke* which discusses service to marginalized communities as a motivating factor in medical school applicants' decisions to pursue a medical degree, and how those aspirations differ significantly between racial groups. This Part is intended to not only bolster this Comment's central argument in favor of race-conscious remediation, but also demonstrate the value of incorporating social science research into arguments concerned with remedying racial inequality through legal means.²⁷

In Part III, I review the evolution of the strict scrutiny standard in affirmative action jurisprudence and revisit the seminal U.S. Supreme Court decisions in light of the specific historical context explored in Part I and what we now know from the social science literature discussed in Part II. Specifically, I argue that the fortieth anniversary of *Bakke* presents an opportunity to abandon the orphaned diversity rationale and harken back to the governmental interest in remedying racial discrimination that was never fully realized. I conclude by positing that the structure and substance of the overall argument presented here materially undermines the colorblind approach that has animated Equal

26. Devon W. Carbado & Daria Roithmayr, *Critical Race Theory Meets Social Science*, 10 ANN. REV. L. & SOC. SCI. 149, 151 (2014) (discussing how social science research, through data and theoretical frameworks provides critical race scholars with a methodology to support their core claims).

27. See *id.*

Protection jurisprudence since *Bakke* and by briefly touching upon the viability of this argument as a blueprint for designing race-conscious admissions programs in the many other higher education settings where race neutrality in admissions reinforces racial disadvantage in the communities served by their graduates.

I. BLACK HEALTH DISPARITIES: A HISTORY

The persistence of disparities in Black health has been called the “tragedy of American health care” and “the civil rights issue of the 21st century.”²⁸ The life expectancy of Blacks is about 3.5 years less than that of whites.²⁹ Black infant mortality rates continue to be more than twice that of whites³⁰ and are even higher in more racially segregated cities.³¹ Blacks die at disproportionate rates from common diseases that are both preventable and treatable, as evidenced by the health outcomes of similarly situated whites.³² While cancer is the United States’s second deadliest disease, Blacks receive their diagnoses at later stages, increasing the likelihood that their illnesses become terminal.³³ Although Black women have lower rates of incidence for breast cancer and uterine cancer than whites, their respective death rates for these ailments are 42 percent and 92 percent higher.³⁴ Advances in medicine and medical technology do not

28. Kevin Outterson, *Tragedy and Remedy: Reparation for Disparities in Black Health*, 9 DEPAUL J. HEALTH CARE L. 735, 735, 740 (2005).

29. Joel Achenbach, *Life Expectancy Improves for Blacks, and the Racial Gap Is Closing*, CDC Reports, WASH. POST (May 2, 2017), http://www.washingtonpost.com/news/to-your-health/wp/2017/05/02/cdc-life-expectancy-up-for-blacks-and-the-racial-gap-is-closing/?utm_term=.91dbf4481ca3 [https://perma.cc/R3D6-TJD4].

30. *Infant Mortality*, *supra* note 8.

31. Amani M. Nuru-Jeter & Thomas A. LaVeist, *Racial Segregation, Income Inequality, and Mortality in US Metropolitan Areas*, 88 J. URBAN HEALTH 270, 277 (2011) (finding that greater racial segregation correlated with increased Black infant deaths whereas the opposite was true for Whites); Thomas A. LaVeist, *Racial Segregation and Longevity Among African Americans: An Individual-Level Analysis*, 38 HEALTH SERVICES RES. 1719, 1726 (2003) (finding a correlation between segregation and Black infant deaths). For a literature review of studies on racial residential segregation and health outcomes, see Michael R. Kramer & Carol R. Hogue, *Is Segregation Bad for Your Health?*, 31 EPIDEMIOLOGIC REVIEWS 178 (2009). However, a recent study found no correlation between Black infant mortality and racial segregation when using a traditional logistic regression, as compared to the ecologic methods used by LaVeist. See Mary O. Hearst, J. Michael Oakes, & Pamela Jo Johnson, *The Effect of Racial Residential Segregation on Black Infant Mortality*, 168 AM. J. EPIDEMIOLOGY 1247, 1252 (2008) (“We do not claim that segregation has no effect on infant mortality rate but rather it is difficult, if not impossible, to disentangle the individual effects from contextual effects.”).

32. *See id.*

33. AM. CANCER SOC’Y, *supra* note 7, at 9.

34. *Id.* at 8.

substantially reduce these disparities. In 1993, for example, three times as many Blacks were diagnosed with diabetes than in 1963.³⁵ Furthermore, Blacks are more likely to suffer from diabetes-related complications such as blindness, kidney disease, and amputations.³⁶ Black men have the highest rates of developing prostate cancer and are twice as likely to succumb to the disease than white men.³⁷ Heart disease remains the deadliest disease among all Americans, but it develops earlier in Blacks³⁸ who are also more likely to have the disease.³⁹ In 2016, 44 percent of patients diagnosed with HIV in the United States were Black, while 47 percent of those who received an AIDS diagnosis were also Black.⁴⁰ In 2015, Blacks accounted for 52 percent of all HIV related deaths despite comprising only 12 percent of the U.S. population.⁴¹

Black health disparities are not limited to physical ailments. Black Americans are 20 percent more likely to experience serious mental health problems than the rest of the population, including high rates of major depression and posttraumatic stress disorder.⁴² And between 1993 and 2012, the suicide rate among Black preadolescent children in the United States nearly doubled.⁴³

These statistics reflect the contemporary effects of a long history of anti-Black racism in healthcare. Present-day Black health disparities are one of the

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35. HARRIET A. WASHINGTON, *MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT* 3 (2006).
 36. AM. DIABETES ASS'N, *Treatment and Care for African Americans*, <http://www.diabetes.org/living-with-diabetes/treatment-and-care/high-risk-populations/treatment-african-americans.html> [https://perma.cc/J39R-UR98].
 37. Dan Gray, *If You're a Black Man, You're Twice as Likely to Die From Prostate Cancer*, HEALTHLINE (July 30, 2018), <https://www.healthline.com/health-news/black-men-twice-as-likely-to-die-from-prostate-cancer#1> [https://perma.cc/7V2Z-BGDN].
 38. *African Americans Live Shorter Lives Due to Heart Disease and Stroke*, AM. HEART ASS'N: NEWSROOM (Oct. 23, 2017), <http://newsroom.heart.org/news/african-americans-live-shorter-lives-due-to-heart-disease-and-stroke> [https://perma.cc/CUE2-WUUZ].
 39. Miriam van Dyke et al., *Heart Disease Death Rates Among Blacks and Whites Aged ≥35 Years—United States, 1968–2015*, 67 MORBIDITY & MORTALITY WKLY REP.: SURVEILLANCE SUMMARIES 1, 7 (2018). See also Larry Husten, *Blacks Face Higher Mortality From Heart Disease, Stroke*, CARDIO BRIEF (Oct. 23, 2017), <http://www.cardiobrief.org/2017/10/23/blacks-face-higher-mortality-from-heart-disease-stroke> [https://perma.cc/GK99-JCGF].
 40. *HIV Among African Americans*, CDC, <http://www.cdc.gov/hiv/group/raciaethnic/africanamericans/index.html> [https://perma.cc/D7VY-TWAR].
 41. *Id.*
 42. *African American Mental Health*, NAT'L ALLIANCE ON MENTAL ILLNESS, <http://www.nami.org/Find-Support/Diverse-Communities/African-American-Mental-Health> [https://perma.cc/8M7W-47RB].
 43. Jeffrey A. Bridge et al., *Suicide Trends Among Elementary School-Aged Children in the United States From 1993 to 2012*, 169 JAMA PEDIATRICS 673, 674 (2015).

many vestiges of America's history of slavery and anti-Black racism.⁴⁴ There is substantial evidence of the state's historical and distinct endorsement of laws and policies that have cumulatively impacted Black health. A closer look at the history of this state action is crucial, as it provides insight into the complicity of the government and the law in creating and perpetuating racial health disparities. It also demonstrates a particularized showing of the governmental action that is a requisite for racial remediation.⁴⁵ The following overview of the history of racism in healthcare emphasizes racist experimentation and discrimination that was sanctioned by the state.

A. Racist Medical Experimentation

The most frequently cited and notorious example of medical experimentation on Black bodies is the Tuskegee Syphilis Study, a government sanctioned medical experiment that endured for four decades between 1932 and 1972.⁴⁶ As part of the study, nearly 400 Black men from Macon County, Alabama were deliberately denied effective treatment for syphilis for doctors to observe and document the natural progression of the disease without participants' knowledge or consent.⁴⁷ The U.S. government was particularly interested in understanding and curing the disease following World War I, during which nearly 600,000 Black men had served in the military as support staff and contracted syphilis at dangerously high rates from European citizens.⁴⁸

As Black infantrymen returned home, the U.S. Health Service worried that the spread of syphilis amongst Black Americans might threaten the health of the

44. Notions of Black intellectual and biological inferiority predate American chattel slavery and can be traced back more than one thousand years ago to presumptions of Western medicine. This Comment focuses specifically on anti-Black racism in American history for relevance purposes, as state action is a requisite for racial remediation in U.S. courts. For further discussion of the predecessors to racism in American medicine see W. Michael Byrd & Linda A. Clayton, *Race, Medicine, and Health Care in the United States: A Historical Survey*, 93 J. NAT'L MED. ASS'N 11S, 14S–18S (2001) [hereinafter Byrd & Clayton, *Race, Medicine, and Health Care*].

45. See *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 504–10 (1989) (quoting Drew S. Days III, Fullilove, 96 YALE L.J. 453, 480–81 (1987) in discussing how states must identify public or private discrimination with specificity before they may use race-conscious relief: "[I]t is essential that state and local agencies also establish the presence of discrimination in their own bailiwicks, based either upon their own fact-finding processes or upon determinations made by other competent institutions").

46. Abigail Perkiss, *Public Accountability and the Tuskegee Syphilis Experiments: A Restorative Justice Approach*, 10 BERKELEY J. AFR.-AM. L. & POL'Y 70, 71 (2008). See also JAMES H. JONES, *BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT* (rev. ed. 1993).

47. Perkiss, *supra* note 46, at 77.

48. *Id.* at 75–76.

white population.⁴⁹ In 1932, the Tuskegee experiment, formally known as the Tuskegee Study of Untreated Syphilis in the Negro Male, began in Macon County, Alabama, which had been identified as having the highest rates of syphilis infections among the surveyed sites.⁵⁰ Participants in the study, many of whom were poor and illiterate, were recruited from the local community and told they were being treated for “bad blood.”⁵¹ In exchange for their participation, the men were guaranteed food, medical testing meals, and burial expenses.⁵² From the outset, participants were misled by researchers into believing they were being treated for their illnesses.⁵³ Instead, licensed physicians employed by the U.S. government monitored the progress of the disease until patients died, withholding treatment as men suffered severe damage to their hearts, brains, and nervous systems, experienced psychosis and blindness, and ultimately died when their vital organs and nervous systems shut down.⁵⁴

After penicillin had been identified and became readily available as an effective treatment of syphilis, the U.S. military began providing the antibiotic to soldiers during World War II to prevent further outbreaks.⁵⁵ To prevent Tuskegee subjects from receiving this medication, the federal government made sure to remove participants from the draft pool to ensure they were not treated for syphilis in the military.⁵⁶

The Tuskegee Experiment is often identified as the primary source of Black Americans’ distrust of the medical community.⁵⁷ The frequency with which Tuskegee is cited “as a prime symbol of past abuses”⁵⁸ is not entirely unwarranted, as many studies have documented this particular scientific experiment’s “damage on the collective psyche of [B]lack Americans.”⁵⁹ Yet while Tuskegee has brought widespread condemnation, due in large part to official recognition of the abuse and a public apology from the U.S.

49. *Id.* at 76.

50. *Id.*

51. This colloquialism was used to describe a group of illnesses including syphilis, anemia, and fatigue. *The Tuskegee Timeline*, CDC, <https://www.cdc.gov/tuskegee/timeline.htm> [<https://perma.cc/6QPC-VLBC>].

52. Perkiss, *supra* note 46, at 77.

53. *Id.* at 78.

54. *Id.* at 71.

55. *Id.* at 78.

56. *Id.*

57. See, e.g., WASHINGTON, *supra* note 35, at 178–80.

58. Vicki S. Freimuth et al., *African Americans’ Views on Research and the Tuskegee Syphilis Study*, 52 SOC. SCI. & MED. 797, 797 (2001).

59. JONES, *supra* note 59, at 220.

government,⁶⁰ prominent medical scholar Harriet Washington has noted the danger in mischaracterizing Tuskegee as the origin of Blacks' reluctance to participate in clinical trials and organ donation.⁶¹ Washington emphasizes that Tuskegee was not the most egregious nor impactful example of anti-Black medical experimentation.⁶² Washington argues that the long history of pain, humiliation, and abuse at the hands of physicians predates Tuskegee; nonetheless, Tuskegee is centered in the discourse around Black apprehension toward clinical and public health research.⁶³ While the Tuskegee Syphilis Study was the longest and remains the most infamous example of medical experimentation on Black subjects, it was certainly not the most impactful in terms of the number of victims.⁶⁴

The violent exploitation of Black bodies for medical experimentation predated Tuskegee—in fact, its origins can be traced to the earliest days of the Republic.⁶⁵ During the antebellum period, white physicians performed medical services on slaves with the assumption that slaves had poor health.⁶⁶ The economic and political interests of slave owners converged with the interests of those physicians exploiting Black bodies for purposes of medical research to advance medicine and white interests.⁶⁷ Black bodies were often used in medical

60. Former president Bill Clinton issued a formal public apology at the White House on May 16, 1997:

The United States Government did something that was wrong—deeply, profoundly, morally wrong. It was an outrage to our commitment to integrity and equality for all our citizens. . . . [W]e can end the silence. We can stop turning our heads away. We can look at you in the eye and finally say on behalf of the American people, what the United States Government did was shameful, and I am sorry.

Bill Clinton, Former U.S. President, Remarks by the President in Apology for Study Done in Tuskegee (May 16, 1997) (transcript available at <https://www.cdc.gov/tuskegee/clintonp.htm>).

61. See Lily Rothman, *The Disturbing History of African-Americans and Medical Research Goes Beyond Henrietta Lacks*, TIME (Apr. 21, 2017, 6:20 PM) <http://time.com/4746297/henrietta-lacks-movie-history-research-oprah> [<https://perma.cc/Q3TQ-6YMU>] (quoting Washington in an interview on the Tuskegee Experiments: “It’s the example that the government has admitted to and acknowledged. It’s so famous that people think it was the worst, but it was relatively mild compared to other stuff.”).

62. WASHINGTON, *supra* note 35, at 181.

63. *Id.* at 180–81.

64. *Id.* at 181.

65. See Outterson, *supra* note 28, at 750.

66. See Byrd & Clayton, *Race, Medicine, and Health Care*, *supra* note 44, at 19S.

67. See Outterson, *supra* note 28, at 749–50; Todd L. Savitt, *The Use of Blacks for Medical Experimentation and Demonstration in the Old South*, 48 J.S. HIST. 331, 334–36, 341–43 (1982) (describing blacks as clinical subjects for medical students and guinea pigs for new techniques and drugs); Kathleen Bachynski, *American Medicine Was Built on the Backs of Slaves. And It Still Affects How Doctors Treat Patients Today.*, WASH. POST (June 4, 2018),

school dissection lessons and as autopsy specimens.⁶⁸ Some slaves expressed a desire to die in summer months when medical schools were not in session in hopes of avoiding having their corpses dissected without their consent.⁶⁹ Even after the Civil War, “night doctors” in the Southern States continued to steal and dissect Black bodies.⁷⁰

Significantly, it was not only the physical health of Blacks that was directly exploited by physicians. Government actors relied upon doctors’ racist assertions regarding Blacks’ inferior mental health status to continue justifying the cause of slavery.⁷¹ The 1840 U.S. Census reported that nearly 1 in every 160 Black persons in the North was clinically insane, as compared to almost 1 in every 1600 slaves in the South.⁷² In between the states of Mississippi and Maine, 1 in every 14 Blacks was designated as a “lunatic” or an “idiot.”⁷³ Proslavery Southerners relied upon the Census data in their claims that Black people needed to be enslaved for their own mental wellbeing.⁷⁴ U.S. Secretary of State John C. Calhoun, who was originally from South Carolina, is believed to have been the mastermind behind the fraudulent data.⁷⁵ However, he did not work alone: Calhoun enlisted the help of two pro-slavery scientists to back his claim.⁷⁶ The legacy of this specific form of exploitation can be seen in contemporary studies indicating how physician racial biases often manifest as a presumption of psychiatric illness in Black patients, including dismissing their complaints of pain as psychosomatic.⁷⁷

The systemic brutality inflicted on Black bodies was not an anomaly carried out by a few deviant doctors, but a practice that was normalized by respected, prominent physicians. One example of a doctor whose violence was rewarded with accolades is Dr. Marion Sims, often referred to as the “father of

https://www.washingtonpost.com/news/made-by-history/wp/2018/06/04/american-medicine-was-built-on-the-backs-of-slaves-and-it-still-affects-how-doctors-treat-patients-today/?utm_term=.058af708a6e3 [https://perma.cc/9HQN-LQE2] (describing experiments used to “promote the healthy births of slave children”).

68. Freimuth et al., *supra* note 58, at 799.

69. *Id.*

70. *Id.*

71. Richard Allen Williams, *Historical Perspectives of Healthcare Disparities: Is the Past Prologue?*, in *HEALTHCARE DISPARITIES AT THE CROSSROADS WITH HEALTHCARE REFORM* 7, 10–12 (Richard Allen Williams ed., 2011). In his 1840 anatomy studies, Dr. Samuel G. Morton concluded that Blacks had smaller brains and thus Blacks were inferior beings. *Id.*

72. *Id.* at 12.

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.* at 10, 12.

77. This will be discussed in depth in Subpart I.1.

gynecology,”⁷⁸ who was elected president of the American Medical Association in 1875 and, until April 2018, was immortalized with his own statue on New York’s Fifth Avenue.⁷⁹ Sims’s statue was said to have been constructed to commemorate the legacy of a groundbreaking physician who developed cures for women’s gynecological disorders, but his advances in medicine relied on the systemic abuse of slave women as his subjects.⁸⁰ Sims’s surgical experiments have been described as “violent struggles,” where slave women had to be restrained by one another as Sims sutured their genitalia with no anesthesia.⁸¹

Another less frequently cited case of anti-Black medical experimentation was conducted by physicians under contract with the U.S. Atomic Energy Commission between 1944 and 1994.⁸² During that time, doctors exposed human subjects to radiation injections without consent or therapeutic intent in more than two thousand experimental projects.⁸³ Many, if not most, of the subjects were Black.⁸⁴

Individual accounts of medical abuse rooted in racism offer additional evidence of how deeply embedded racism is in the policies and practices of medical institutions, and those accounts provide examples of the collective mistrust that results. In 1961, Fannie Lou Hamer went to her local hospital to have a benign uterine fibroid tumor removed, only to later discover that her surgeon had removed her uterus, sterilizing her without her permission.⁸⁵ Her experience catalyzed her political activism, and she became a “lifelong opponent of birth control.”⁸⁶ Later that decade, an increase in federally-financed birth control clinics continued to breed similar mistrust.⁸⁷ Blacks expressed suspicion

78. Nadja Sayej, *J Marion Sims: Controversial Statue Taken Down but Debate Still Rages*, GUARDIAN (Apr. 21, 2018, 5:00 AM), <http://www.theguardian.com/artanddesign/2018/apr/21/j-marion-sims-statue-removed-new-york-city-black-women> [https://perma.cc/7VHB-UW3K].

79. WASHINGTON, *supra* note 35, at 1. The city of New York removed the sculpture, located next to Central Park, in April 2018 due in large part to eight years of protests by Black activists followed by a petition from the local community which garnered over 26,000 signatures. Monuments honoring Sims remain standing in various locations across the country, including South Carolina. Sayej, *supra* note 78.

80. WASHINGTON, *supra* note 35, at 1–2.

81. *Id.* at 2.

82. *Id.* at 218.

83. *Id.* See generally Michael McCally et al., *U.S. Government-Sponsored Radiation Research on Humans 1945–1975*, 1 MED. & GLOBAL SURVIVAL 4 (1994) (recounting the dozens of radiation experiments sponsored by the government from the mid-1940s to 1970s affecting at least 695 subjects).

84. WASHINGTON, *supra* note 35, at 218.

85. *Id.* at 189–90.

86. *Id.* at 190.

87. See *id.* at 198.

of the government's intent in supporting well-funded birth control initiatives in Black neighborhoods at the same time health advocates failed to address high rates of infectious disease, infant mortality, poor nutrition, and lack of access to quality hospitals and physicians.⁸⁸ By 1983, Black women made up 43 percent of the women sterilized in federally funded family planning programs, despite the fact that only 12 percent of the U.S. population was Black at the time.⁸⁹

The case of Henrietta Lacks offers another illustration of an exploitative medical practice that has left a legacy of mistrust among Black patients. In 1951, Lacks was unsuccessfully treated for cervical cancer at Johns Hopkins Hospital, which was one of the only hospitals in the country that treated poor Black citizens.⁹⁰ During a biopsy, a sample of her cancer cells was collected and sent to a lab, where it was discovered that unlike other cells, Lacks's cells did not die and thus proved to be invaluable to medical research.⁹¹ Although her cells played a critical role in the development of the polio vaccine and in vitro fertilization, and continue to be used to study the effects of toxins, drugs, hormones, and viruses, the value and use of her cells was not disclosed to her own family for years.⁹² In the 1970's medical researchers approached her family members to ask for blood samples in hopes of further researching Lacks's cells, yet still did not disclose their possession or continued usage of her cells to her own children.⁹³ While Johns Hopkins was not a state entity, both its function as a sole provider of healthcare for Black communities and its disregard for Lacks's bodily autonomy fit into an established narrative of neglectful government policies and practices.

Both before and after Tuskegee, Black Americans have viewed the American healthcare system as complicit in a long history of experimental abuse, and a rich oral tradition within Black communities has sustained negative perceptions of healthcare.⁹⁴ In 1990, a prominent Johns Hopkins University

88. *Id.* at 200.

89. *Id.* at 203.

90. See *The Legacy of Henrietta Lacks*, JOHNS HOPKINS MED., <http://www.hopkinsmedicine.org/henrietalacks/index.html> [https://perma.cc/HNV3-ZUNR].

91. *Id.*

92. See *id.*; Andrea K. McDaniels, *Henrietta Lacks's Family Wants Compensation for Her Cells*, WASH. POST (Feb. 14, 2017), http://www.washingtonpost.com/local/henrietta-lacks-family-wants-compensation-for-her-cells/2017/02/14/816481ba-f302-11e6-b9c9-e83fce42fb61_story.html [https://perma.cc/JXC5-PM3M]. For additional reading on the life of Henrietta Lacks and her revolutionary cells, see generally REBECCA SKLOOT, *THE IMMORTAL LIFE OF HENRIETTA LACKS* (2010).

93. McDaniels, *supra* note 92.

94. Peter A. Clark, *A Legacy of Mistrust: African-Americans, the Medical Profession, and AIDS*, 65 LINACRE Q. 66, 66–67 (1998).

doctor testified before the National Commission on AIDS that the Black community was “already alienated from the health care system and the government.”⁹⁵ Nearly a decade later, another researcher noted that the Black women in her study displayed a lack of trust in white providers, a shared belief that doctors disregard or minimize the prevalence of diseases that specifically impact the Black community, and a very real fear that they might be used as guinea pigs.⁹⁶

The tendency of Blacks to underutilize health services or to prefer treatment by physicians of their own race cannot be fully understood absent this historical context. The exclusionary nature of public healthcare policy discussed in the next Subpart presents another vantage point from which the modern-day persistence of racial health disparities is analyzed as a product of state action.

B. Racism in Healthcare Policy

A central component of critical race scholarship is to provide alternatives to dominant narratives of civil rights progress. The appalling state of Black health at the end of the Civil War in 1865 warrants disruption of patriotic emancipation narratives in this critical tradition.⁹⁷ The reality that racial inequity in access to land, employment, capital, and education continued after the end of legal slavery has been the subject of much literature. However, the massive amounts of pain, suffering, and death that freedmen experienced due to the outbreak of epidemic disease at the war’s end; the collapse of slavery’s paternalistic healthcare system; and the slave health subsystem with no viable alternatives to replace them;⁹⁸ and the massive displacement of Black people have received scant attention.⁹⁹ Despite Blacks suffering from “[t]he distress and medical crises that . . . were a hidden cost of war and an unintended outcome of emancipation,”¹⁰⁰ reconstructionists avoided discussion of their health and wellbeing out of fears that it would undermine notions of progress in the postbellum South.¹⁰¹ In the absence of any reliable healthcare system or

95. Freimuth et al., *supra* note 58, at 799.

96. *Id.*

97. JIM DOWNS, SICK FROM FREEDOM: AFRICAN-AMERICAN ILLNESS AND SUFFERING DURING THE CIVIL WAR AND RECONSTRUCTION 6 (2012).

98. DOWNS, *supra* note 97, at 7–8; Byrd & Clayton, *Disparities*, *supra* note 10, at 471; Outtersson, *supra* note 28, at 751–52.

99. See DOWNS, *supra* note 97, at 6 (“The few and scattered references of freedpeople suffering from the challenges of emancipation have been overlooked because these episodes do not fit into patriotic narratives of the Civil War.”).

100. DOWNS, *supra* note 97, at 7.

101. *Id.*

infrastructure to treat their medical needs, freedmen were generally forced to pay for their own healthcare with severely limited resources or turn to the federal government and Northern philanthropists for charity and limited public health programs.¹⁰² Although the Freedmen's Bureau had established a Medical Division, it proved to be highly disorganized and nowhere near sufficient to meet the overwhelming need of newly freed Blacks.¹⁰³ The Freedmen's Bureau constructed more than forty Black hospitals and almshouses across the South and employed hundreds of doctors, nurses, and aides to treat more than one million newly freed Blacks.¹⁰⁴ Despite this effort, lack of supplies, personnel shortages, and infrastructure with limited functionality undermined efforts to provide quality healthcare.¹⁰⁵ Notably, one of the Bureau's few lasting achievements was the establishment of what is now Howard University Hospital in Washington, D.C., which, along with Meharry Medical College, offered virtually the only sites for training Black medical professionals between 1910 and 1970.¹⁰⁶ The Freedman's Bureau Medical Department lasted only three years before Blacks were forced to rely on local governments and charities to meet their healthcare needs.¹⁰⁷

As hospitals became the primary site for medical care post-Civil War, Blacks were forced to respond to segregated healthcare facilities by constructing their own hospitals that were inherently inferior due to a lack of resources.¹⁰⁸ The medical profession remained segregated as well. As the private, white American Medical Association grew in power, public hospitals began requiring that physicians be active members of the local AMA chapter to practice.¹⁰⁹ The requirement effectively shut out Black physicians from practicing as the medical community maintained an illusion of equal opportunity.¹¹⁰ This discrimination continued into the 1960's until the passage of the Civil Rights Act of 1964 and Medicare in 1965.¹¹¹

102. Outterson, *supra* note 28, at 751–52.

103. *Id.* at 753–54.

104. DOWNS, *supra* note 97, at 9.

105. Outterson, *supra* note 28, at 753–54.

106. *Race, Medicine, and Health Care*, *supra* note 44, at 20S.

107. Outterson, *supra* note 28, at 754.

108. *See id.* at 759.

109. *Id.* at 760.

110. *Id.*

111. *Id.* at 760–61.

1. State-Sanctioned Segregation Under the Hill-Burton Act of 1946

The most explicit example of the federal government's support for a segregated healthcare system is found in the Hill-Burton Act of 1946, also known as the Hospital Survey and Construction Act.¹¹² From 1946 to 1962, Hill-Burton provided more than \$13 billion in federal funds for the construction and modernization of nonprofit and publicly owned medical facilities.¹¹³ Roughly 30 percent of all hospital construction projects from 1949–1962 received financial assistance under this plan.¹¹⁴ While a provision of the Act required beneficiaries to provide community services and care in exchange for federal funds, the Department of Health, Education, and Welfare inadequately enforced the requirement, adversely impacting Black access to healthcare.¹¹⁵ The U.S. government not only failed to enforce the community service requirement but also sanctioned racial segregation through the Hill-Burton Act that permitted separate but equal facilities.¹¹⁶ This was not surprising given that one of the drafters, Senator Lister Hill of Alabama, was an unabashed segregationist who would later vow to oppose the ruling in *Brown v. Board of Education*.¹¹⁷

Blacks were faced with the dilemma of accepting the segregation statute and applying for funding for racially segregated facilities, or otherwise risk losing the opportunity for much needed improvements in Black hospitals.¹¹⁸ Ultimately, Hill-Burton funding was used to build 104 healthcare facilities that practiced overt racial exclusion.¹¹⁹ Hill-Burton funding was also used to build and modernize more than 7000 “non-discriminatory” facilities, which were nonetheless allowed to segregate by ward, room, and floor.¹²⁰ So long as everyone had access to a medical facility that received Hill-Burton funds, the General Counsel of the Department of Health, Education, and Welfare clarified, segregation of patients by race and denial of staff privileges to physicians on the basis of race were lawful.¹²¹

112. See *id.* at 764–65; Karen Kruse Thomas, *The Hill-Burton Act and Civil Rights: Expanding Hospital Care for Black Southerners, 1939–1960*, 72 J. S. HIST. 823, 823 (2006).

113. See Outterson, *supra* note 28, at 764–65. See also U.S. DEP’T HEALTH & HUMAN SERVS., *Medical Treatment in Hill-Burton Funded Healthcare Facilities*, <https://www.hhs.gov/civil-rights/for-individuals/hill-burton/index.html> (last updated Nov. 27, 2015) [<https://perma.cc/KB6S-JUWE>].

114. Outterson, *supra* note 28, at 765.

115. *Id.* at 765–66.

116. *Id.* at 768.

117. *Id.*

118. *Id.* at 768–70.

119. *Id.* at 770.

120. *Id.*

121. *Id.* at 770–71.

Segregation under Hill-Burton remained firmly in place until the 1963 Fourth Circuit decision in *Simkins v. Moses H. Cone Memorial Hospital*.¹²² In that case, the court found that a private hospital's refusal to admit Black patients or grant Black staff privileges violated the Fifth and Fourteenth Amendments, pointing to the defendant's receipt of federal Hill-Burton funds as the state action which triggered a constitutional analysis.¹²³ In response to the ruling, Congress extended the Hill-Burton program in 1964 for an additional five years with the "separate but equal" clause removed.¹²⁴ Nonetheless, the pervasive state-sanctioned damage to Black health had already been done. Throughout two decades of the largest expansion of federally-funded healthcare facilities in the nation's history, Blacks were excluded outright from receiving care, or relegated to the basements of "integrated" medical facilities.

2. Medicare and Medicaid

Blacks' access to quality healthcare has historically been limited by structural and institutional bias, as evidenced in the organization of America's healthcare system around ability to pay.¹²⁵ Because Blacks have less wealth and are more likely to work in low-wage jobs with inadequate employer-sponsored health coverage, Blacks are more likely to be uninsured or rely on Medicaid for their health coverage.¹²⁶ In 1965, Congress passed and President Johnson signed Medicare and Medicaid, Titles XVIII and XIX of the Social Security Act, respectively, into law in order to address disparities in access to healthcare.¹²⁷ Medicare provided hospital and medical insurance for Americans aged 65 and older and was funded entirely by the federal government,¹²⁸ while Medicaid created a state- and federally-funded program

122. 323 F.2d 959 (4th Cir. 1963).

123. *Id.* at 969–70 (holding the statute unconstitutional under both equal protection and due process).

124. Outterson, *supra* note 28, at 772.

125. Ruqaiyah Yearby, *Sick and Tired of Being Sick and Tired: Putting an End to Separate and Unequal Health Care in the United States 50 Years After the Civil Rights Act of 1964*, 25 HEALTH MATRIX 1, 5 (2015).

126. *Id.* at 17.

127. History, CTR. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/About-CMS/Agency-information/History> (last updated June 20, 2018) [<https://perma.cc/28EE-VZ3J>].

128. History of SSA During the Johnson Administration 1963-1968, SSA, <https://www.ssa.gov/history/ssa/lbjmedicare1.html> [<https://perma.cc/PZ7X-HD8Y>].

for certain low-income people,¹²⁹ including a substantial percentage of Blacks.¹³⁰ Johnson moved to end virtually all forms of legal segregation in healthcare settings by requiring adherence to Title VI of the Civil Rights Act of 1964, which prohibited discrimination in federal health programs, as a prerequisite to receipt of federal money for Medicare and Medicaid.¹³¹ Incentivized by receipt of federal funds, physicians and hospitals voluntarily participated in both federal programs. The Department of Health, Education, and Welfare required participating hospitals to comply with Title VI in order to receive Medicaid funding, prompting more than 3000 hospitals to change their practices to come into compliance with the law.¹³² By connecting Title VI to Medicare and Medicaid funding, hospitals and other medical facilities became desegregated almost immediately.¹³³ In communities most impacted by hospital segregation, the Title VI prohibitions against both intentional discrimination and disparate impact resulted in healthcare improvement for Blacks right after its passage.¹³⁴ An oft-cited study documenting this trend showed a substantial reduction in Black infant mortality rates between 1965 and 1971.¹³⁵ The authors of the study identified a causal relationship between hospital desegregation and the drop in Black infant mortality, proving empirically that state regulation of healthcare facilities saved Black lives.¹³⁶

While most hospitals opted into receiving federal funds through Medicare, some effectively continued to discriminate against Blacks by refusing to see patients covered by Medicaid, or by closing down and moving to more affluent White neighborhoods.¹³⁷ This hospital white flight continued over the next several decades. A 1992 report found that among 190 urban community

129. *Using Medicaid to Support Working Age Adults With Serious Mental Illnesses in the Community: A Handbook. A Brief History of Medicaid*, OFF. ASSISTANT SECRETARY FOR PLAN. & EVALUATION (Jan. 24, 2005), <https://aspe.hhs.gov/report/using-medicaid-support-working-age-adults-serious-mental-illnesses-community-handbook/brief-history-medicaid> [<https://perma.cc/77R7-S6JS>].

130. “Since about one-third of the poor were black [at the time], it was assumed that Medicaid would reduce disparities in access to care by race, as well as by income.” Karen Davis et al., *Health Care for Black Americans: The Public Sector Role*, 65 *MILBANK Q.* 213, 220 (1987). *Id.* at 217–20 (discussing the positive changes in Black health trends since the enactment of Medicaid and Medicare).

131. *Id.* at 227; Outterson, *supra* note 28, at 773.

132. Outterson, *supra* note 28, at 774–75.

133. Yearby, *supra* note 125, at 8.

134. Outterson, *supra* note 28, at 775.

135. Douglas Almond, Kenneth Y. Chay & Michael Greenstone, *Civil Rights, the War on Poverty, and Black-White Convergence in Infant Mortality in the Rural South and Mississippi* 18, Figure 1a (Mass. Inst. of Tech. Dep’t of Econ., Working Paper No. 07-04, 2006).

136. *Id.* at 1, 6–7.

137. See Yearby, *supra* note 125, at 20.

hospitals that closed between 1980 and 1987, a high percentage of Blacks in the surrounding neighborhood was the most significant factor leading to the closure.¹³⁸ Forty-five percent of hospitals that opened in 1970 were closed by 2010, and 60 percent of those closures took place in predominantly Black neighborhoods.¹³⁹ Closures in St. Louis and Detroit are often cited as the most egregious example of this trend toward hospital resegregation. In the 1970s, St. Louis had eighteen hospitals in Black neighborhoods; in 2010, only one remained.¹⁴⁰ In 1960, Detroit had forty-two hospitals in Black neighborhoods; in 2010, only four remained.¹⁴¹ Hospital closures substantially affected Black health, as entire communities were forced to seek care in a lone hospital that was understaffed and underresourced. Despite the government's effort to desegregate medical facilities through Title VI, it did nothing to stop the institutional racism that manifested in hospital closures.¹⁴²

Although de jure discrimination in healthcare remains illegal today, in the era of the Affordable Care Act, Blacks continue to be disproportionately impacted by the 2012 Supreme Court decision in *NFIB v. Sebelius*, which permitted states to opt out of the ACA Medicaid expansion for people living at or below 138 percent of the federal poverty level.¹⁴³ Most southern states, where segregation of healthcare facilities is particularly pervasive, have rejected the Medicaid expansion to the extent that four million eligible adults remain uninsured.¹⁴⁴ A 2015 study by the Kaiser Family Foundation found that 24 percent of Blacks eligible for Medicaid under the expansion live in states that have refused to participate.¹⁴⁵ States cited ideological and cost concerns in their reasoning for opting out, and 30 percent of people who lack access to affordable

138. *Id.*

139. *Id.*

140. *Id.*

141. *Id.*

142. *See id.* at 19–22.

143. *See* Judy Lubin, *Fifty Years After Medicare Desegregated Hospitals, Blacks Still Fighting for Health Care Access*, HUFFPOST: THE BLOG (Feb. 17, 2015, 4:56 PM), http://www.huffingtonpost.com/judy-lubin/fifty-years-after-medicar_b_6685204.html [<https://perma.cc/AAZ4-MY5J>]; Vann R. Newkirk II, *America's Health Segregation Problem*, ATLANTIC (May 18, 2016), <http://www.theatlantic.com/politics/archive/2016/05/americas-health-segregation-problem/483219> [<https://perma.cc/MMD8-UBNS>]; *see also* *NFIB v. Sebelius*, 567 U.S. 519 (2012).

144. Lubin, *supra* note 143.

145. Samantha Artiga, Anthony Damico & Rachel Garfield, *The Impact of the Coverage Gap for Adults in States not Expanding Medicaid by Race and Ethnicity*, KAISER FAM. FOUND. (Oct. 26, 2015), <https://www.kff.org/disparities-policy/issue-brief/the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity> [<https://perma.cc/7FK5-GYW8>].

health coverage are Black.¹⁴⁶ While states' rejection of the expansion may appear facially race-neutral, the role that these same states have historically played in discriminating against Blacks in healthcare and the reality that Blacks rely heavily on Medicaid strongly suggest that race may motivate the decisions of state legislatures to reject the expansion.

The role of the state in permitting and endorsing racial disparities in health by sanctioning cruel medical experimentation, in funding segregated health facilities, and in failing to adequately address the disparate impact that hospital closures and Medicaid policy decisions have on Black communities makes a strong case for application of the Equal Protection Clause, which requires past adverse state action to justify race-conscious remediation. Now that the myth of the state as merely a passive participant in structural and institutional race discrimination in health has been debunked, the next Part focuses on the interpersonal racial discrimination that occurs in the context of medical care.

II. WHY RACE MATTERS IN HEALTHCARE

The possibility that service to underserved communities could be a compelling state interest justifying the consideration of race in admissions was considered by the *Bakke* Court.¹⁴⁷ Significantly, the *Bakke* Court did not dismiss the U.C. Davis Medical School's claim that this was a potentially constitutional state interest outright, but merely suggested that there was not enough evidence in the record to support the claim.¹⁴⁸ This Part addresses the evidentiary omission in *Bakke* by presenting existing data supporting the conclusion that medical students of color are more likely to pursue jobs in underserved communities where racial disparities in health are particularly pervasive. Furthermore, it will advance the argument that race should be considered in admission to health professions schools by discussing why race matters in the context of medical care, specifically looking at physicians' racial bias, patients' racial preferences, and the role that physicians' racial identity plays in reinforcing, expanding, or mitigating racial disparities in health.

146. Newkirk II, *supra* note 143; see also *Where the States Stand on Medicaid Expansion*, ADVISORY BOARD (Nov. 5, 2018, 12:51 PM), <https://www.advisory.com/daily-briefing/resources/primers/medicaidmap> [https://perma.cc/3275-CZKV].

147. *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265, 310–11 (1978).

148. *Id.*

A. Improving Service to Underserved Communities

In her examination of empirically derived compelling state interests that could be considered as alternatives to the diversity rationale in affirmative action jurisprudence, Meera E. Deo identifies “rewarding a desire to serve” as a possibility in the context of race-conscious law school admissions, given the data showing that public interest is the most popular career goal among African American and Latino law students.¹⁴⁹ She notes, however, that the data does not offer substantive proof of a likelihood to serve underserved communities, but merely suggests a preference worthy of further study.¹⁵⁰

While the data exploring the relationship between law students’ racial identity and the tendency to pursue public service in the legal profession may be limited, this relationship has been the subject of much literature in the context of the medical profession. Because of the extensive body of research on racial health disparities that has been produced over the course of the past several decades, there is an abundance of concrete data illustrating the relationship between the race of medical students and practicing physicians, and the likelihood that they will serve or currently serve underserved communities.¹⁵¹ In the 1970s and 1980s, frequently referred to as “the affirmative action era,” minority students began entering medical schools in larger numbers.¹⁵² Several studies have compared the practice patterns of minority physicians with their white counterparts.¹⁵³ While the samples, sources of data, and methodologies have differed from study to study, each study has come to a very similar conclusion: Minority physicians tend to be more likely to practice in underserved areas, and are more likely to serve a higher percentage of minorities within their patient populations.¹⁵⁴

The earliest known study to document this trend was a nationally representative survey conducted by the federal government, the 1975 National Ambulatory Medical Care survey. The government’s findings confirmed that “black physicians practice predominantly in metropolitan areas.”¹⁵⁵ The results

149. Meera E. Deo, *Empirically Derived Compelling State Interests in Affirmative Action Jurisprudence*, 65 HASTINGS L.J. 661, 699–702 (2014).

150. *Id.* at 700–02.

151. See, e.g., Raynard Kington, Diana Tisnado & David M. Carlisle, *Increasing Racial and Ethnic Diversity Among Physicians: An Intervention to Address Health Disparities?*, in THE RIGHT THING TO DO, THE SMART THING TO DO: ENHANCING DIVERSITY IN THE HEALTH PROFESSIONS 57, 64–77 (Brian D. Smedley et al. eds., 2001).

152. *Id.* at 64.

153. *Id.* at 64–65.

154. *Id.*

155. *Id.*

of a 1978 survey of alumni of Howard University College of Medicine, a predominantly Black school,¹⁵⁶ showed that 60 percent of respondents were practicing or planning to practice in a large city, while 32 percent reported they were practicing or intended to practice in an “inner-city area.”¹⁵⁷ A large-scale study conducted by the American Association of Medical Colleges (AAMC) examined the practice patterns for medical school graduates in the class of 1975 by the graduates’ practice location, specialty board certification, and patient population served.¹⁵⁸ Significantly, this graduating cohort was selected due to concern that segregation and overt forms of discrimination limited previous students’ ability to choose their practice location and patient populations.¹⁵⁹ Results indicated that minority graduates were twice as likely to practice in federally designated manpower shortage areas.¹⁶⁰ Predicting the criticism that minority physicians likely practiced in underserved areas because they faced obstacles finding employment in other areas, the authors noted that the average score on the performance index for minority physicians practicing in underserved areas was higher than the average score for minority physicians practicing in non-shortage areas.¹⁶¹

A smaller study of the UCLA Medical School Class of 1975 found that minority physicians were more likely to serve patients of their own ethnic group and Medicaid recipients, and to work in federally designated health-manpower shortage areas.¹⁶² In a 1995 review of a nationally representative sample of 15,000 adults, patients receiving healthcare from minority physicians were more likely to be ethnic minorities, have low income, and have no Medicaid or insurance.¹⁶³ A 1996 examination of healthcare service delivery in California found that communities with high proportions of minority residents were more likely to have a shortage of physicians and that Black physicians tended to practice in poorer areas and areas with fewer physicians.¹⁶⁴ In a nod to the question addressed in the AAMC study discussed above, researchers specifically looked at graduates from the highly competitive U.C. San Francisco Medical School to test whether physicians practicing in underserved areas did so as a result of choice

156. *About Us*, HOWARD U. C. MED., <https://medicine.howard.edu/about-us> [<https://perma.cc/UQ83-HFD8>].

157. Kington et al., *supra* note 151, at 65.

158. *Id.*

159. *Id.* at 65–66.

160. *Id.* at 66.

161. *Id.*

162. Stephen N. Keith et al., *Effects of Affirmative Action in Medical Schools—A Study of the Class of 1975*, 313 NEW ENG. J. MED. 1519, 1521–22 (1985).

163. Kington et al., *supra* note 151, at 70–71.

164. *Id.* at 67–68.

rather than limited opportunities.¹⁶⁵ Similar to the AAMC study findings, results showed that Black physicians from a top medical school nonetheless tended to practice in areas containing a higher percentage of Black residents when compared to non-Black physicians.¹⁶⁶

Another 1996 study of physicians from several states found that minority physicians were more likely to serve minorities, the poor, and Medicaid recipients.¹⁶⁷ A 1997 survey of 1581 generalist physicians from the classes of 1983 and 1984 demonstrated that generalist physicians from underrepresented minorities were more likely to serve medically underserved populations.¹⁶⁸ Similarly, a 1996 study of 1044 pediatricians found that underrepresented minorities were more likely to care for minority patients, Medicaid recipients, and uninsured patients.¹⁶⁹ Studies published at the turn of the century suggested that this trend would not end in the foreseeable future. In 2000, a large study of 2955 physicians in the graduating classes of 1983 and 1984 found that being an underrepresented minority and growing up in an underserved area were both predictors of providing care to underserved population postgraduation.¹⁷⁰ A 2001 study of patients of pediatric residents found that minority pediatricians disproportionately served patients of their same ethnicity, even when controlling for language ability.¹⁷¹ More recently, recognizing that most of the research on minority physicians focused solely on primary care doctors, Walker, Moreno, and Grumbach's study examined whether underrepresented minority physicians from a wide variety of specialties were also more likely to practice in underserved communities.¹⁷² Consistent with previous findings, the results demonstrated a tendency for underrepresented racial groups in medicine to practice their respective specialties in underrepresented communities to a

165. *Id.* at 68.

166. *Id.*

167. Joel C. Cantor et al., *Physician Service to the Underserved: Implications for Affirmative Action in Medical Education*, 33 INQUIRY 167 (1996).

168. Gang Xu et al., *The Relationship Between the Race/Ethnicity of Generalist Physicians and Their Care for Underserved Populations*, 87 AM. J. PUB. HEALTH 817, 819–20 (1997).

169. Cooper & Powe, *supra* note 16, at 2.

170. Howard K. Rabinowitz et al., *The Impact of Multiple Predictors on Generalist Physicians' Care of Underserved Populations*, 90 AM. J. PUB. HEALTH 1225 (2000).

171. Jann L. Murray-Garcia et al., *The Service Patterns of a Racially, Ethnically, and Linguistically Diverse Housestaff*, 76 ACAD. MED. 1232, 1263 (2001). The results were such that, across all visits to Latino patients, Latino residents were nearly twice as likely to tend to Latino patients even when there was no language barrier. This suggests that language ability does not account for the disproportionate service patterns. *Id.*

172. Kara Odom Walker, Gerardo Moreno & Kevin Grumbach, *The Association Among Specialty, Race, Ethnicity, and Practice Location Among California Physicians in Diverse Specialties*, 104 J. NAT'L MED. ASS'N 46, 49 (2012).

greater extent than white specialist physicians.¹⁷³ A 2017 study analyzed the characteristics of medical students planning to work in medically underserved areas.¹⁷⁴ Researchers found that recruiting students with certain demographic characteristics would be a more efficient way to increase the number of physicians working in medically underserved communities, in lieu of changing the curriculum or offering clinical opportunities.¹⁷⁵

Since the 1978 *Bakke* decision, there has been an abundance of literature analyzing the relationship between the race of medical practitioners and the likelihood of service to underrepresented communities. As an empirical matter, the relationship is significant, and may have met the evidentiary standard Justice Powell expected to seriously consider the claim that improving healthcare delivery in underserved communities was a compelling state interest the U.C. Davis Medical School sought to achieve. In the four decades since *Bakke*, however, an increase in public skepticism toward affirmative action has only been matched by the Court's insertion of evidentiary hurdles universities must overcome to justify any consideration of race in admissions.¹⁷⁶ This hostility towards affirmative action has most recently manifested itself in a U.S. Department of Justice probe into admissions practices at elite universities, on the basis that they discriminate against Asian Americans.¹⁷⁷ Given this context, it would be beneficial for universities to strengthen their argument that race-conscious admissions practices are justifiable by showing that consideration of race is likely to achieve their stated goals. Research indicating the salient role physician race plays in perpetuating racial disparities, as well as studies suggesting that diversifying the profession is a viable remedy, open up a promising path forward.

173. *Id.*

174. Vivian Irizarry Gatell et al., *Characteristics of Medical Students Planning to Work in Medically Underserved Settings*, 28 J. HEALTH CARE FOR POOR & UNDESERVED 1409 (2017).

175. *Id.* at 1410.

176. *Fisher v. Univ. of Tex. (Fisher I)*, 570 U.S. 297, 312 (2013) (noting that a reviewing court must be convinced that there are no workable race-neutral alternatives that would produce the educational benefits of diversity, and that the existence of a nonracial approach which promotes diversity would preclude a university from considering race). This appeared to be a somewhat more stringent standard than that announced in *Grutter*, where the Court required good-faith consideration of race neutral alternatives on the part of the university, but seemed to give universities more deference in determining their viability. *Grutter*, 539 U.S. at 339.

177. See Lila Thulin, *Justice Department Is Investigating Potential Racial Bias in Harvard's Admission Practices*, SLATE: THE SLATEST (Nov. 22, 2017, 3:11 PM), http://www.slate.com/blogs/the_slatest/2017/11/22/department_of_justice_is_investigating_potential_racial_bias_in_harvard.html [<https://perma.cc/5K4Y-MAD6>].

B. The Role of Physician Race in Health Disparities

1. Physician Racial Bias

In his critically acclaimed memoir, *Black Man in a White Coat*, physician Damon Tweedy recalls an unsettling moment in 1996 when he witnessed his white colleagues reveal their racial bias against a Black patient.¹⁷⁸ Due to chest pains, Gary, a 55-year-old Black man, was admitted to a hospital for the first time in his life.¹⁷⁹ The attending physicians, observing that Gary's blood pressure was slightly higher than normal, recommended that he begin taking daily medication.¹⁸⁰ Gary objected to taking medicine and suggested that he instead try lifestyle interventions such as diet and exercise first; the doctors later laughed as they consulted about his case outside of his room, debating what psychiatric illness he could have had that caused him to defy their medical authority.¹⁸¹ Tweedy recalls that his firsthand account is similar to an experience Henry Louis Gates details in his memoir *Colored People*, where he describes how one doctor discounted his painful hip as "psychosomatic," before being taken to another hospital where he had to have several surgeries for a slipped epiphysis.¹⁸² Black patients being shortchanged by white doctors, it seemed, was not a rare or unlikely incident, but part of a broader pattern of racial discrimination.

The percentage of Black physicians has never adequately reflected their demographic share of the American population,¹⁸³ and that discrepancy significantly shapes healthcare delivery to Black patients. The same year Tweedy witnessed the biased treatment Gary received, the medical field exploded with scientific literature affirming his observation that Blacks experience racial bias in the healthcare system. The most widely cited publication is the 2003 Institute of Medicine Report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, which details evidence that providers' racial bias, discrimination, and stereotyping of patients directly contribute to health disparities.¹⁸⁴ This report is consistent with the findings in Kevin Schulman's famous study, *The Effect of Race and Sex on Physicians' Recommendations for Cardiac*

178. DAMON TWEEDY, *BLACK MAN IN A WHITE COAT: A DOCTOR'S REFLECTION ON RACE AND MEDICINE* 133 (Picador paperback ed. 2016).

179. *Id.* at 135.

180. *Id.* at 137.

181. *Id.* at 137–41.

182. *Id.* at 131–32.

183. Newkirk II, *supra* note 143.

184. *Summary to UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 1–12 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003).

Catheterization, which revealed that race and sex of the patient were significantly associated with the physician's decision to make referrals for cardiac catheterization, with Black women receiving the lowest referral rates of all groups.¹⁸⁵

In a study of medical culture and the acculturation of doctors in training, one resident relayed the stereotype that Black patients are characterized as being “dreadfully sick and their social life is so disorganized that they are ‘non-compliant’ and living in a state of chaos, with a disorganized household, or that they are socially isolated.”¹⁸⁶ A 2016 study demonstrated that half of a sample of white medical students and residents carried false beliefs about biological differences between Blacks and whites that lead to bias in pain assessment and treatment recommendations.¹⁸⁷ In the latter study, the white students and residents who held these false beliefs were more likely to recommend inadequate treatment for the pain of Black patients, with the differential treatment being related to erroneous beliefs such as “Blacks’ skin is thicker than whites’,” “Blacks age more slowly than whites,” or “[w]hites have larger brains than Blacks.”¹⁸⁸

Recent research has also highlighted the role clinicians’ implicit bias plays in perpetuating healthcare disparities.¹⁸⁹ In 2007, Dr. Alexander Green was the first researcher to demonstrate an association between physicians’ levels of implicit bias and treatment decisions, finding that physicians’ unconscious anti-Black bias translated into less desirable treatment for black patients and more desirable treatment for white patients.¹⁹⁰ Significantly, not one of the physicians in the study expressed any racial bias on questionnaires asking them to indicate any explicit preferences they had between Black and white patients.¹⁹¹ Subsequent studies have shown that healthcare professionals harbor the same levels of implicit bias as the broader population.¹⁹²

185. *Id.* at 10–11. See also Kevin Schulman et al., *The Effect of Race and Sex on Physicians’ Recommendations for Cardiac Catheterization*, *NEW ENG. J. MED.* 618, 623 (1999).

186. Mary-Jo DelVecchio Good et al., *The Culture of Medicine and Racial, Ethnic, and Class Disparities in Healthcare*, in *UNEQUAL TREATMENT*, *supra* note 184, at 594, 602.

187. Kelly M. Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 *PROC. NAT’L ACAD. SCI.* 4296 (2016).

188. *Id.* at 4298–300.

189. See, e.g., Dayna Bowen Matthew, *Toward a Structural Theory of Implicit Racial and Ethnic Bias in Health Care*, 25 *HEALTH MATRIX* 61, 61–62 (2015).

190. *Id.* at 67–68.

191. *Id.* at 68.

192. See Chloë FitzGerald & Samia Hurst, *Implicit Bias in Healthcare Professionals: A Systematic Review*, 18 *BMC MEDICAL ETHICS* 1 (2017).

Despite its dramatic implications, the phenomenon of patient racial preferences has been less rigorously researched until recently.¹⁹³ In 2010, researchers at the University of Michigan Health System, the University of Pennsylvania, and the University of Rochester published a groundbreaking study on the “culture of accommodation” in hospital settings.¹⁹⁴ The study revealed that patients frequently request a physician of a different race, gender, or religion than the one initially assigned, and that hospitals routinely accommodate such requests.¹⁹⁵ Requests are most often granted when the patient making the request is a racial minority or a woman. Black, Hispanic, and Asian patients’ perceptions of their treatment are generally more positive when they are treated by a provider of the same race.¹⁹⁶ Kimani Paul-Emile notes that these racial preferences present healthcare providers with an ethical dilemma, where they must choose between competing obligations: their professional obligation to provide equitable care and their ethical duty to respect patient autonomy and advance patients’ medical best interests.¹⁹⁷ Although Paul-Emile characterizes the phenomenon of patients’ racial preferences as “one of medicine’s open secrets,”¹⁹⁸ such preferences, particularly those requested by minorities, should come as no surprise given the discrimination minorities have historically been proven to be subject to. Research has shown that Blacks’ experience or awareness of discrimination in the healthcare system and medical research has cultivated a culture of mistrust that makes them less likely to seek medical care or comply with recommended treatment. In the context of healthcare, then, the negative impact of racial bias is not a unilateral phenomenon, but a complex interplay of bias and mistrust rooted in a long history of racism and health inequality.

2. Race Concordance as Race-Conscious Remediation

That racial biases exist in the medical community and negatively impact the quality of treatment Black patients receive is not a new revelation. Similarly, the notion that increasing diversity within the medical profession is a powerful way to remedy racial health disparities is not new. In its 2004 report titled *Missing Persons: Minorities in the Health Professions*, the Sullivan Commission on

193. See Kimani Paul-Emile, *Patients’ Racial Preferences and the Medical Culture of Accommodation*, 60 UCLA L. REV. 462, 464 (2012).

194. *Id.* at 470–71.

195. *Id.* at 471.

196. *Id.*

197. *Id.* at 472.

198. *Id.* at 470.

Diversity in the Healthcare Workforce found “that the failure of the health professions to keep pace with the changing demographics in America ‘may be an even greater cause of disparities in health access and health outcomes than the persistent lack of health insurance for tens of millions of Americans.’”¹⁹⁹ A 2015 study of remaining health disparities following implementation of the Affordable Care Act corroborated this theory, finding that by two years into the largest expansion of health insurance in half a century, perceived quality of healthcare among minorities remained lower than among whites.²⁰⁰ The study’s authors concede that financial barriers such as cost-sharing requirements may interfere with access to higher quality care but acknowledge the role that lack of physician cultural competence and mistrust of health institutions due to historic abuses play in significantly shaping minority perceptions of healthcare quality.²⁰¹ Lisa Ikemoto has argued that a “close examination of health care’s culture reveals how its systemic practices express racist, nativist, and ethnocentric beliefs and values that, in turn, produce racially disparate health outcomes.”²⁰² In order to address racial disparities in health, she suggests that interventions be made at the organizational, structural, and clinical levels.²⁰³ One of her recommendations is that affirmative action programs in schools, hospitals, and other healthcare settings can serve as “anti-racist interventions at the organizational level.”²⁰⁴

Ikemoto is one of several legal scholars who have proposed affirmative action programs in health professions schools as a means to address racial disparities in health status. In his argument for reparations to remedy Black disparities in health, Kevin Outterson cited affirmative action in education as an appropriate intervention, justifying race-conscious admissions programs on reparational grounds separate from a diversity standpoint.²⁰⁵ Democratic National Committee Chairman Tom Perez, in his previous capacity as a law professor at the University of Maryland, wrote extensively on the subject.²⁰⁶ He points out that

199. Thomas E. Perez, *Enhancing Access to Health Care and Eliminating Racial and Ethnic Disparities in Health Status: A Compelling Case for Health Professions Schools to Implement Race-Conscious Admissions Policies*, 9 J. HEALTH CARE L. & POL’Y 77, 94 (2006) (quoting THE SULLIVAN COMM’N, MISSING PERSONS: MINORITIES IN THE HEALTH PROFESSIONS: A REPORT OF THE SULLIVAN COMMISSION ON DIVERSITY IN THE HEALTHCARE WORKFORCE IV–V (2004)).

200. Benjamin D. Sommers et al., *Beyond Health Insurance: Remaining Disparities in US Health Care in the Post-ACA Era*, 95 MILBANK Q. 43, 48–53 (2017).

201. *Id.* at 61.

202. Lisa C. Ikemoto, *Racial Disparities in Health Care and Cultural Competency*, 48 ST. LOUIS U. L.J. 75, 80 (2003).

203. *Id.* at 77.

204. *Id.* at 125.

205. Outterson, *supra* note 28, at 790.

206. See generally Perez, *supra* note 199.

many health professional schools and organizations were highly active in the *Grutter* and *Gratz* decisions precisely because the benefits of diversity in healthcare settings are so consequential.²⁰⁷ Noting the vulnerability of the diversity rationale and the “razor-thin 5–4 majority” it garnered in *Grutter*, Perez advances the notion of improving healthcare access as a rationale for advancing race-conscious admissions and recruitment in professional health schools.²⁰⁸

The critical next step then is not to merely continue emphasizing the proposition that diversifying the medical profession may help alleviate racial health disparities, but to explicitly identify how this intervention will function. This is especially important given the increasingly high evidentiary burden placed on universities to defend race-conscious policies as “narrowly tailored,” as articulated in *Fisher I* and *Fisher II*. To many, it might seem intuitive that individuals who have experienced racial discrimination and diminished access to societal resources would be in the best position to improve service delivery, access, and outcomes among disadvantaged populations, but this is not necessarily the case. Nor is it the case that Black identity necessarily translates to the advancement of Black interests.²⁰⁹ Nonetheless, there appears to be a consensus in the medical community that physicians from racial minority backgrounds may possess culturally specific knowledge, skills, and experience that reduce barriers to the physician-patient relationship for racial minority patients.²¹⁰ In anticipation of having the necessity of considering race interrogated during litigation, it is necessary to build a case that the consideration of race will, in fact, significantly contribute to mitigating Black health disparities.

Although the body of research in this area is not as extensive as research on physician racial bias, some preliminary findings on the impact of what the medical community refers to as physician-patient race concordance generally support the hypothesis that race-concordant relationships have a positive impact on patient experiences and health outcomes. The 2003 publication of *Unequal Treatment* generated a great deal of interest in how having a doctor of

207. *Id.* at 87.

208. *Id.* at 88–98.

209. See Carla D. Pratt, *Way to Represent: The Role of Black Lawyers in American Democracy*, 77 FORDHAM L. REV. 1409, 1419 (2009) (clarifying the article’s argument that “[B]lack lawyers bring a unique ‘voice’ or viewpoint to democratic discussions and decision making is not an essentialist claim that all black lawyers do, in fact, or should think alike.” But merely a suggestion that Black lawyers in government serve a representative role by virtue of their intimate familiarity with the lived experiences of Black people in America).

210. See THE RIGHT THING TO DO, THE SMART THING TO DO, *supra* note 151, at 85.

the same race might impact health disparities for minority patients.²¹¹ Early studies focused on the impact race-concordant physician-patient relationships had on communication.²¹² Researchers found that race-concordant visits were longer and that patients rated their levels of satisfaction higher as compared to race-discordant visits.²¹³ More specifically, patients viewed race-concordant physicians as more participatory and collaborative in their decisionmaking styles, which increased patient satisfaction.²¹⁴ Later studies built on these findings by analyzing the significance of race-concordant relationships to care utilization and health outcomes. The first and most widely cited study to address the impact of race-concordance on health utilization found that patients who are of the same racial or ethnic groups as their physicians are more likely to use needed health services and less likely to postpone or delay seeking care, compared to patients whose regular doctors were of a different group. The researchers concluded that “given the under-representation of minorities among the ranks of health care providers, minority patients are less likely to be race concordant compared to whites . . . [this] tendency to underutilize health services in the absence of doctor-patient race concordance might therefore exacerbate racial disparities in health.”²¹⁵ A 2010 study looked at the effects of physician-patient race-concordance on medication adherence for patients with cardiovascular disease.²¹⁶ Race concordance for Black patients was associated with adherence to all of their medications.²¹⁷ In 2015, researchers found that Black women being screened for cancer who were paired with race-concordant navigators obtained their results faster when compared to women that were paired with race-discordant navigators.²¹⁸ The authors concluded that

211. See Cooper & Powe, *supra* note 16, at 1.

212. See *id.* at vi.

213. *Id.*

214. *Id.* at v–vi.

215. Thomas A. LaVeist, Amani Nur-Jeter & Kiesha E. Jones, *The Association of Doctor-Patient Race Concordance with Health Services Utilization*, 24 J. PUB. HEALTH POL’Y 312, 320 (2003).

216. Traylor et al., *supra* note 17, at 1172.

217. *Id.* at 1176.

218. Charlot et al., *supra* note 18, at 1481. A patient navigator, also referred to as a patient advocate, is defined as:

[A] person who helps guide a patient through the healthcare system. This includes help going through the screening, diagnosis, treatment, and follow-up of a medical condition, such as cancer. [The] navigator helps patients communicate with their healthcare providers so they get the information they need to make decisions about their health care . . . and may also help patients set up appointments for doctor visits and medical tests and get financial, legal, and social support.

NAT’L CANCER INST., *NCI Dictionary of Cancer Terms*, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/patient-navigator> [<https://perma.cc/H529-K49U>].

patient-navigator racial concordance could be beneficial to minority women, especially given the poorer cancer outcomes experienced within their racial and gender group.²¹⁹

The existence of racial disparities in health, the reality that the provider racial bias and patient racial preferences exacerbates those disparities, and the assertion that increasing diversity in the profession could significantly remedy those disparities share a strong, empirically-supported foundation. They advance the notion that, in the context of healthcare, “the benefits of diversity are ‘not theoretical but real.’”²²⁰ In Part III, I advance the argument that the use of race-conscious admissions in medical schools is justified by the state’s interest in remedying racial health disparities, and I analyze its strengths and challenges in the context of the ever-evolving standards in affirmative action jurisprudence.

III. LEGAL ANALYSIS: JUSTIFYING RACE-CONSCIOUS MEDICAL SCHOOL ADMISSIONS IN A STRICT SCRUTINY REGIME

[Y]ou can’t educate your way out of this problem. You can’t health care-access your way out of this problem. There’s something inherently wrong with the system that’s not valuing the lives of [B]lack women equally to white women.²²¹

As Ta-Nehisi Coates articulated in *The Case for Reparations*, America has never fully reckoned with its legacy of racism.²²² He identifies slavery, Jim Crow, the “separate but equal” regime, and racist housing policy as some of the “compounding moral debts” America has yet to contend with.²²³ In Coates’s view, reparations for Black Americans should not merely consist of compensation for historical injustices, but demand a “revolution of American consciousness” that calls into question America’s image of itself as a great democracy.²²⁴

The Supreme Court’s 1978 decision in *Bakke* wrote into law resistance to the notion that America has moral debts to account for when it rejected the U.C.

219. *Id.* at 1483.

220. Perez, *supra* note 199, at 86 (quoting Grutter v. Bollinger, 539 U.S. 306, 330 (2003)).

221. Martin, *supra* note 2 (quoting Raegan McDonald-Mosley, the chief medical director for Planned Parenthood Federation of America).

222. Ta-Nehisi Coates, *The Case for Reparations*, ATLANTIC (June 1, 2014), <https://www.theatlantic.com/magazine/archive/2014/06/the-case-for-reparations/361631> [<https://perma.cc/XM6Z-7HJJ>].

223. *Id.*

224. *Id.*

Davis Medical School's historically informed rationales for its race-conscious admissions policy and introduced a colorblind approach to its analysis of affirmative action in higher education.²²⁵ In the years preceding *Bakke*, it had become clearly established law that the Court would apply strict scrutiny analysis to any government action that involves a suspect classification, including race.²²⁶ Prior to *Bakke*, of course, challenges to state action involving race were typically cases in which marginalized, nonwhite racial groups contested discriminatory laws intended to at best maintain and at worst exacerbate their marginalization. That almost exclusively nonwhite people petitioned the Court in the years between 1868 and 1978 to review laws with racial classifications under the Equal Protection Clause of the Fourteenth Amendment was consistent with the Amendment's original purpose when it was ratified in 1868: to establish civil and legal rights for Black Americans after the abolition of slavery by providing protection from racist state and local laws under the United States Constitution.²²⁷ Accordingly, when Alan Bakke, a white male applicant, filed a lawsuit against the U.C. Regents for allegedly denying him admission to U.C. Davis Medical School based on his race, it would not have been outlandish to infer that the Court would reject Bakke's efforts—to paraphrase Brennan's dissent—to use the Equal Protection Clause against those whom it was intended to set free.²²⁸ Yet, in affirming the application of strict scrutiny analysis to policies involving benign racial classifications, the Court did exactly that, thereby ushering in a strict scrutiny regime under which public universities must develop and defend their consideration of race in higher education admissions.²²⁹ In short, the Court effectively endorsed a false equivalency between laws intended to subordinate Black people and laws intended to remedy the effects of anti-Black discrimination. Remarkably, in the four decades since this critical decision was handed down, Justices who otherwise purport to be originalists have not only sanctioned this weaponization of the Equal Protection

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

226. The origins of the application of strict scrutiny in equal protection analyses are commonly traced to *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) and *Korematsu v. United States*, 323 U.S. 214, 216 (1944). See ERWIN CHEMERINSKY, *CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES* 645, 767, 902–03 (2d ed. 2002).

227. Louisa M. A. Heiny, *Radical Abolitionist Influence on Federalism and the Fourteenth Amendment*, 49 AM. J. LEGAL HIST. 180, 194 (2007) (discussing how the language of the Fourteenth Amendment reflects and is consistent with radical abolitionist ideals, despite the various ways the Amendment has been interpreted by the Court).

228. *Bakke*, 438 U.S. at 326 (Brennan, J., dissenting).

229. *Id.* at 299 (Powell, J., plurality opinion).

Clause's original meaning but rejected outright the notion that race should be a factor in higher education admissions at all.²³⁰

It is in this context that the arguments in defense of affirmative action asserted here have emerged. To be clear, I do not endorse the application of strict scrutiny in evaluating the constitutionality of race-conscious admissions programs, or the notion that the consideration of race in admissions is itself a form of racial discrimination. Nor is the overall argument elucidated here a reflection of naïve faith in the Court's willingness to reconsider the colorblind ideology underlying its affirmative action jurisprudence. The history, empirical data, and legal arguments presented are, however, an effort to revitalize the narrative around affirmative action precisely at a time where it is believed to be on its last legs. The July 2018 retirement of Justice Kennedy, who has often been viewed as a critical swing vote on the Court when it comes to decisions concerning affirmative action, and the recent appointment of conservative Justice Kavanaugh by President Trump, invite efforts to safeguard the fragile diversity rationale and simultaneously revive arguments around the urgency of remedying racial discrimination. While it is very unlikely that the Court will reexamine its use of strict scrutiny in evaluating race-conscious admissions programs, even the slightest possibility that it will uphold race-conscious policies that meet the strict scrutiny standard makes this legal analysis a worthwhile endeavor.

230. The judicial philosophy of Justices Clarence Thomas, Antonin Scalia, and William Rehnquist is generally understood to be rooted in originalism. See André Douglas Pond Cummings, *Grutter v. Bollinger, Clarence Thomas, Affirmative Action and the Treachery of Originalism: "The Sun Don't Shine Here in This Part of Town"*, 21 HARV. BLACKLETTER L.J. 1, 14 (2005). Originalists are committed to interpreting the Constitution according to the textual meaning of the language of the document as was intended by the Framers of the Constitution. *Id.* As legal scholars have identified, however, affirmative action programs are indeed consistent with the original meaning of the Fourteenth Amendment. See, e.g., David Gans & Adam Winkler, *Online Fisher Symposium: Affirmative Action Is Consistent With Original Meaning*, SCOTUSBLOG (Sep. 5, 2012, 11:28 AM), <https://www.scotusblog.com/2012/09/online-fisher-symposium-affirmative-action-is-consistent-with-original-meaning/> [<https://perma.cc/AA92-SKEZ>]. The Fourteenth Amendment's text permits legislators to enact race-conscious measures in pursuit of equality, and the Framers of the Amendment affirmatively enacted such policies following its ratification. *Id.* Nonetheless, in his *Grutter* dissent, Justice Thomas lamented that the majority, which upheld the University of Michigan's race-conscious admissions policy, "still cannot commit to the principle that racial classifications are *per se* harmful and that almost no amount of benefit in the eye of the beholder can justify such classifications." *Grutter v. Bollinger*, 539 U.S. 306, 371 (2003) (Thomas, J., concurring in part and dissenting in part). Justice Scalia similarly called for a *per se* rejection of race as a factor in admissions ("The Constitution proscribes government discrimination on the basis of race, and state-provided education is no exception."). *Id.* at 349 (Scalia, J., concurring in part and dissenting in part).

To say that challenges lie ahead in persuading the Court to uphold the consideration of race in medical school admissions would be an understatement. Since *Bakke*, the strict scrutiny standard triggered by the use of race, even as a “factor of a factor of a factor of a factor,” has become narrower, and therefore increasingly difficult to meet.²³¹ Yet the justification of the use of race as a means to reduce racial health disparities by diversifying medical school classrooms has significant practical advantages in the context of this legal terrain. For one, proponents of race-conscious admissions have the option to meet the justices of the Supreme Court where they are now; that is, the arguments in defense of affirmative action asserted here are not disaggregated from the Court’s diversity rationale. They can, however, refine our understanding of the value of diversity, rendering its consideration more justifiable and urgent since the need for the intervention is, quite literally, a matter of life or death.

Linking the discourse around racial disparities in healthcare to the affirmative action debate also advances the narrative around race-conscious admissions by drawing attention to its broader social meaning. It presents an opportunity to steer the Court away from diversity as its solely recognized compelling governmental interest toward a race analysis that is not only more compelling, but has greater empirical support. The possibility of remedying racial health disparities as a compelling state interest could open the door for the Court to consider racial disparities in other spheres where racial-discordance has been empirically proven to negatively impact quality of life and outcomes. This could include the criminal justice and education systems, to name only a couple of prominent examples. Finally, a third advantage of identifying the elimination of racial health disparities as a state interest is that it unapologetically positions race front-and-center amidst a contemporary legal debate about whether race-neutral alternatives, specifically consideration of an applicant’s socioeconomic status, would be a more appropriate intervention.²³² As discussed in previous parts, the medical community itself does not deny the salience of race in disparate treatment and health outcomes, and has recommended racial inclusion in the medical profession as a viable solution to this problem.²³³ To suggest that the consideration of socioeconomic status of medical school

231. *Fisher v. Univ. of Tex (Fisher I)*, 570 U.S. 297, 336 (2013) (Ginsburg, J., dissenting) (citing *Fisher v. Univ. of Tex.*, 645 F. Supp. 2d 587, 608 (W.D. Tex. 2009)).

232. See Cheryl L. Harris, *Fisher’s Foibles: From Race and Class to Class not Race*, 64 UCLA L. REV. DISC. 648 (2017) (discussing how the arguments and rationales asserted before the Court in *Fisher II*, 136 S. Ct. 2198, 2210 (2016) reinforced a framework based on the notion that class considerations can be an effective substitute for race in higher education admissions).

233. See *supra* Part II.

applicants would be a plausible solution to the issue at hand would be to ignore the robust research that identifies race as central to both the problem and the remedy. This Part reexamines themes in the debate around race-conscious policies that have been brought to the Court's attention and elaborates on the advantages of using the framing suggested in this Comment within a strict scrutiny regime.

A. Revisiting the Remedial Rationale: Specificity Requirements in *Croson*

Although remedying racial health disparities is characterized as a new compelling state interest in this Comment, it should be emphasized that a remedial rationale for affirmative action has previously come before the Court. In *City of Richmond v. J.A. Croson Co.*,²³⁴ the Court found a city-sponsored Minority Business set-aside program, which required prime contractors of the city's work to subcontract at least 30 percent of the contract to minority businesses, to be unconstitutional under the Equal Protection Clause of the Fourteenth Amendment.²³⁵ In concluding that the set-aside program failed strict scrutiny analysis, the majority narrowed the remedial rationale put forth by the city by declaring that any set-aside program must be justified by specific evidence of past discrimination, rather than vague estimates.²³⁶ The Court rejected statistical evidence of generalized discrimination as lacking probative value and clarified that Richmond would have to "identify that discrimination, public or private, with some specificity before they may use race-conscious relief."²³⁷ This would include a showing of prior discrimination by the specific governmental entity involved in the litigation. To be more specific, the Court was looking for the existence of racial discrimination specifically in the Richmond construction industry. Due to the impracticability of meeting this standard, *Croson* has frequently been interpreted as effectively eliminating the remedial rationale from affirmative action jurisprudence.

While *Croson* is not typically analyzed in the context of affirmative action in higher education, the form of empiricism being brought to bear here is not terribly unlike the evidentiary showing the Court sought in evaluating Richmond's set-aside program. A reading of the standard set forth in *Croson* as *impractical* rather than *impossible*, presents a window of opportunity for race-

234. 488 U.S. 469 (1989).

235. *Id.* at 511.

236. *Id.* at 509–10.

237. *Id.* at 504.

conscious programs that are meticulously crafted to account for racial discrimination within a specific institution. A medical school affirmative action policy intended to remedy the effects of a long history of state-sanctioned racial discrimination in healthcare could be a viable opportunity to meet the high *Croson* standard. As discussed in Part II, the state has been an active participant in racial discrimination in healthcare by endorsing experimentation, funding separate and unequal healthcare facilities, and drafting healthcare policies that disparately impact Black citizens. If the Court requires that a state demonstrate the existence of past racial discrimination specifically in the healthcare industry, one need look no further than the Hill-Burton Act of 1946, or cite to the medical experiments that resulted in the loss of hundreds of Black lives. It is undeniable that the racial discrimination in these contexts was a product of state action. State universities looking to identify remedying past discrimination as the justification for race-conscious admissions programs to medical schools can research whether Hill-Burton funds were used in constructing their states' medical facilities, whether racist medical experiments were conducted within their state, and how state hospitals have historically dealt with Medicaid recipients to create a showing of past discrimination that is as particularized to their local healthcare system as possible. If applicable, state universities should also be prepared to identify how their particular institutions may have played a direct role in racial discrimination.

Given the difficulty of defending and the uncertainty of relying on the remedial rationale as it is commonly understood—an effort to remedy discrimination that occurred in the past—proponents of race-conscious admissions may opt to rely on evidence of historical discrimination to buttress existing justifications for the diversity rationale, or argue that remedying racial disparities warrants recognition of a new compelling governmental interest altogether. Whichever doctrinal move is chosen, the state's sanctioning of racial discrimination in healthcare, or state action, must remain central to the argument. Emphasis on state action can be used to bolster arguments that the state has an obligation to remedy health disparities as they currently stand.

B. Revisiting the Remedial Rationale in *Bakke*: Meeting Evidentiary Requirements

Notwithstanding the notoriety of the Court's decision in *Bakke*, Justice Powell did, perhaps inadvertently, leave open the possibility that remedial justifications for race-conscious admissions could pass constitutional muster if sufficient evidence is provided in the record to support a school's intended goals.

In *Bakke*, which involved a challenge to race-conscious admissions at U.C. Davis Medical School, the university offered four defenses of its special admissions program. The first was “reducing the historic deficit of traditionally disfavored minorities in medical schools and in the medical profession”; the second was “countering the effects of societal discrimination”; the third was improving access to healthcare in underserved communities; and the fourth was “obtaining the educational benefits that flow from an ethnically diverse student body.”²³⁸ Justice Powell rejected the historic deficit argument and societal discrimination rationales, critiquing the latter as “an amorphous concept of injury that may be ageless in its reach into the past.”²³⁹ In reviewing the third defense, Powell acknowledged that “[i]t may be assumed that in some situations a State’s interest in facilitating the health care of its citizens is sufficiently compelling to support the use of a suspect classification.”²⁴⁰ Powell rejected the medical school’s claim on an evidentiary basis stating “there is virtually no evidence in the record indicating that petitioner’s special admissions program is either needed or geared to promote that goal” but did not reject the reasoning underlying the defense.²⁴¹ Powell’s opinion effectively upheld only the diversity rationale, and emphasized that even this interest could not be achieved by separate or dual track admissions programs.

For those who welcome empirical evidence and view social science data as a valid representation of people’s lived experiences, the mischaracterization of societal discrimination as an amorphous concept of injury is relatively easy to debunk. As discussed in Part I, data documenting the persistence of disparities in Black health is abundant and has been legitimized within the medical community. Moreover, the cause of these disparities has been directly linked to a long history of medical abuse, experimentation, and racist healthcare policy endorsed by the state. When analyzed in tandem, it becomes increasingly difficult to dismiss notions of racial discrimination as either amorphous or identifiable only in the past. Accordingly, presented with a well-documented historical account of racism within a particular institution and empirical evidence which suggests that that history has contemporary manifestations, the Court may concede that the amorphousness of racism as understood by Powell may no longer hold up in an era where unprecedented access to information and data indicates otherwise.

238. *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265, 306 (1978).

239. *Id.* at 265.

240. *Id.* at 310.

241. *Id.*

Having pushed back on notions of racism as amorphous brings us to another defense of affirmative action rejected by Justice Powell: that the race-conscious admissions program designed by U.C. Davis Medical School was intended to improve medical service delivery to underserved communities. To reiterate, Powell did not express aversion to the validity of this rationale or its relationship to race-conscious admissions in the medical school context; his primary concern was the lack of evidence showing the U.C. Davis program was geared toward that goal. As discussed in Part II, interest in the tendency of minority physicians to work in underserved communities inspired a great deal of research post-*Bakke*.²⁴² Because this data was not available or presented to the Court during the *Bakke* litigation, one might assume that presenting an overwhelming amount of evidence indicating that the race of physicians impacts the facilitation of healthcare would ensure the Court's recognition of an additional compelling state interest. Given the vast amount of research detailing persistence of racial health disparities, it is possible that the modern Court would agree with Powell that improving healthcare delivery to remedy health disparities is sufficiently compelling to support the use of a suspect classification.

Since *Bakke*, however, the Court's focus on diversity as the default accepted rationale in its affirmative action jurisprudence has shifted the focus of the debate to what narrow tailoring means in the context of race-conscious admissions. Accordingly, we may presume for purposes of this analysis that the Court might recognize the improvement of service delivery to underserved communities as a compelling governmental interest. The more challenging hurdle is proving that a race-conscious medical school admissions programs is narrowly tailored to achieve that goal.

C. From *Grutter* to *Fisher II*: Narrow Tailoring Post-*Bakke*

Because the diversity rationale has remained intact since it was first articulated in *Bakke*, challenges to race-conscious admissions programs over the last several decades have gradually shifted the focus of the Court away from analyzing whether diversity is in fact a compelling state interest toward scrutiny of how narrowly tailored an admissions program has been designed to achieve the goal of diversity. Twenty-five years after *Bakke*, the Court upheld diversity as a compelling state interest for use in race-conscious admissions to the University of Michigan Law School in *Grutter v. Bollinger*, but the Court doubled

242. See *supra* Part II.

down on the narrow tailoring prong in its majority opinion.²⁴³ In the 5–4 opinion, the majority required admissions committees to show that they had conducted a holistic review of candidates in which race was one factor among many considered in the evaluation of an application, that they had not used quotas, and that they had “sufficiently considered workable race-neutral alternatives.”²⁴⁴ Justice O’Connor also emphasized the requirement that race-conscious admissions be “limited in time,” declaring that “a permanent justification for racial preferences would offend [the] fundamental equal protection principle.”²⁴⁵

The diversity rationale remained in place following *Fisher I*; however, the Court raised the evidentiary bar for universities even higher by requiring that admissions committees convince the trial court that the use of race is necessary to achieve the compelling state interest it aims to serve.²⁴⁶ *Fisher I* laid out three governing principles courts must follow in evaluating the constitutionality of a public university’s affirmative action program. Adhering to affirmative action precedent, the Court continued to require that race-conscious admissions programs survive strict scrutiny, including a demonstration that its use of a racial classification is necessary to achieve a constitutionally permissible and substantial state interest.²⁴⁷ Second, the Court acknowledged that university admissions programs are entitled to some judicial deference, but cautioned that complete judicial deference would not be proper, and fixed quotas or specified percentages of a particular racial or ethnic group would remain impermissible.²⁴⁸ Third, and most significantly, the Court further narrowed the narrow tailoring requirement articulated in *Grutter*, clarifying that universities are owed no deference in determining whether their use of race is narrowly tailored.²⁴⁹ Rather, going forward, a public university would bear the significant burden of proving that a “nonracial approach” would not effectively promote the state interest its admissions model seeks to achieve.²⁵⁰ This showing would “not require exhaustion of every *conceivable* race-neutral alternative,” but would place upon the university the burden of demonstrating the insufficiency of any workable race-neutral alternatives that are available.²⁵¹

243. *Grutter v. Bollinger*, 539 U.S. 306, 343 (2003).

244. *Id.* at 335–40.

245. *Id.* at 342.

246. *Fisher v. Univ. of Tex. (Fisher I)*, 570 U.S. 297, 298–99 (2013).

247. *Id.* at 308–09.

248. *Id.* at 308.

249. *Id.* at 311.

250. *Id.* at 312.

251. *Id.* (quoting *Grutter v. Bollinger*, 539 U.S. 306, 339 (2003)).

While the Court did not ultimately rule on the constitutionality of the University of Texas's admissions program in *Fisher I*, it did uphold its practices in *Fisher II*, albeit with more words of caution from both the majority and Justice Alito in his lengthy dissent. Should a university meet the high standard articulated by the Court, Justice Kennedy warned that universities must regularly evaluate their data to tailor their approaches to race-conscious admissions "in light of changing circumstances, ensuring that race plays no greater role than is necessary to meet its compelling interest."²⁵² He emphasized that universities could not perpetually rely on their admissions policies without refinement, and have an "ongoing obligation to engage in constant deliberation and continued reflection" with respect to their admissions policies.²⁵³ Kennedy further specified that the university's goals could not be "elusory or amorphous," but "must be sufficiently measurable to permit judicial scrutiny of the policies adopted to reach them."²⁵⁴ While one might accurately observe that the *Fisher II* majority further narrowed an already seemingly impenetrable doctrinal space, Justice Alito in his dissent advocated for a standard with even more constraints. Lamenting the difficulty of measuring the "educational benefits of diversity" and the vague meaning of a "critical mass" of racially diverse students, Alito criticized the Court for giving the University of Texas too much deference in demonstrating that its program is narrowly tailored and accused the university of being intentionally imprecise to insulate its admissions practices from meaningful judicial review.²⁵⁵ In a nod to existing criticism that affirmative action programs in education disadvantage Asian Americans, he added that the UT's race-conscious admissions program discriminated against individuals of Asian descent.²⁵⁶ Finally, he argued that UT had not put forth an honest effort in utilizing race-neutral alternatives to achieve diversity—specifically, intensified outreach efforts, the refinement of its Top Ten Percent Plan, and the placement of heavier weight on an applicant's socioeconomic status.²⁵⁷ Notably, the lattermost alternative has been the topic of much debate around workable alternatives to affirmative action, in spite of the lack of proof that class-based interventions would adequately address racial inequality.²⁵⁸

252. *Fisher v. Univ. of Tex.* (*Fisher II*), 136 S. Ct. 2198, 2210 (2016).

253. *Id.* at 2215.

254. *Id.* at 2211.

255. *Id.* at 2222–23 (Alito, J., dissenting).

256. *Id.* at 2227.

257. *Id.* at 2236.

258. See Harris, *supra* note 232, at 678.

D. Looking Forward: Narrowly Tailoring Medical School Admissions Under *Fisher II*

The decision in *Fisher II* was considered a hard-fought victory for proponents of affirmative action in higher education, but the cautionary tone of the opinion reminds us of the fragility of the diversity rationale given the rigidity with which the race-conscious admissions programs will be scrutinized for narrow tailoring going forward. An advantage of remedying racial health disparities as a compelling state interest is that medical schools need not attempt to circumvent or contest the feasibility of this high evidentiary standard to prevail under the narrowly tailored prong of the doctrinal test. Assuming that the Court concedes that remedying racial disparities in health is indeed a compelling governmental interest, public medical schools would have to make the threshold showing that race-neutral alternatives would not achieve their stated goals. As discussed in Part II, the persistence of racial biases amongst medical providers and the resulting differential treatment of Black patients, coupled with the deeply rooted mistrust Black patients harbor toward medical practitioners, is believed to substantially contribute to Black disparities in health. Both the history and the social science data bring into focus an interactional racial dynamic that permeates medical service delivery.

Given the salient role race plays in the delivery of healthcare and the willingness of patients to seek out and accept it, the viability of race-neutral alternatives becomes difficult to defend. To use one of Justice Alito's race-neutral alternatives as an example, an admissions policy that places a heavier weight on socioeconomic status would likely do little to achieve the goal of remedying racial disparities. For one, studies of class-based admissions policies have shown that this intervention fails to ameliorate the racial disparities in university enrollment.²⁵⁹ To implement an admissions policy that positions consideration of race as secondary to consideration of socioeconomic status risks the formation of medical school cohorts that are not racially diverse enough to have the meaningful impact on remedying racial disparities that is suggested here. Second, a class-based intervention effectively ignores the research emphasizing the centrality of race to issues of racial disparities and proposed remedies.²⁶⁰ In the research on the impact of patient-provider race concordance on Black health outcomes and patient satisfaction, socioeconomic status was simply not relevant. Because a physician's socioeconomic background would be

259. See William C. Kidder, *How Workable Are Class-Based and Race-Neutral Alternatives at Leading American Universities?*, 64 UCLA L. REV. DISC. 100, 131 (2016).

260. See *supra* Part II.

virtually impossible for a patient to ascertain while receiving treatment, there is little indication that a physician's experience with economic disadvantage would function to make patients feel more comfortable with seeking and adhering to treatment.

Finally, in the medical school context, admissions decisions based on socioeconomic disadvantage could potentially adversely impact the likelihood that a medical student will work in underserved communities where racial disparities in health are particularly pervasive. Data showing the increased likelihood that minority medical students serve poor communities upon graduation looked specifically at physician race, not class. Students from economically disadvantaged backgrounds may actually have more of an incentive to earn higher wages as physicians by working in the private sector, or in more affluent communities, given the unique financial challenges and cumulative effects that come with being a first-generation student and/or a family's sole professional breadwinner.

In the context of a race-conscious approach to medical school admissions justified by the need to remedy racial health disparities, Justice Kennedy's warning that universities cannot perpetually rely on race-conscious admissions without adjusting to changing circumstances or having sufficiently measurable goals is well taken. The necessity of forming a racially diverse medical school class bears a direct relationship to the existence of racial disparities in health. Should racial disparities in health decrease, or cease to exist at all, universities would be expected to analyze the impact their contribution to diversifying the medical profession has made on these improvements. An empirical analysis of this type would certainly take time to develop, but given the Court's demonstrated inclination to suggest arbitrary cut off points for the use of affirmative action, the time needed for universities to collect and analyze data on the public health impact of its race-conscious admissions programs in this scenario would function as a safeguard for the program's constitutionality in the interim. The inaugural class that benefits from a race-conscious program would have to at least complete medical school and residency training before the impact of its racial diversity on health outcomes could be assessed. Since health disparities have long been the subject of medical research, the continued participation of the medical field in evaluating the intersection of race and health could alleviate some of the administrative challenges universities would otherwise face in assessing the impact of their policies. Additionally, in the event that the ultimate goal of eliminating racial health disparities is achieved, this would not necessarily signal the end of the need for race-conscious admissions. Rather, assuming increased racial inclusion in the medical profession is found to

have substantially contributed to remedying racial health disparities, admissions programs would want to refine their admissions policies not to cease consideration of race, but to ensure that the medical profession sustains an ideal health system where racial diversity of physicians is the norm and patients' race does not negatively impact individuals' health outcomes.

In addition to advocating for class-based interventions, opponents of race-conscious admissions policies will likely propose intensified outreach and recruitment efforts targeted toward underrepresented groups as viable race-neutral alternatives. While outreach and recruitment strategies targeted toward aspiring Black physicians may increase the number of Black medical school applicants, it does not follow that these same applicants would be admitted to medical schools under a race-blind policy. Compared to other racial groups, Black students were accepted to medical schools less frequently from 2013–2014 and 2015–2016 even though their MCAT and GPA scores were comparable to those of other applicants.²⁶¹ Lower acceptance rates based on GPA reflect the reality of a segregated K–12 education system, and the barriers minority students face at all points along the educational pipeline. As with other standardized tests, the MCAT has been shown to accurately predict some measures of medical school success, but, as two medical school deans have observed, “it primarily measures one’s ability to perform well on tests (as well as one’s ability to procure test-prep resources or simply the time needed to adequately prepare).”²⁶² As long as medical schools continue to rely on measures such as GPA and standardized test scores devoid of the context in which they were earned, outreach and recruitment strategies could very well increase the number of Black applicants who nonetheless get rejected during a race-neutral admissions process.

Cultural competence training presents another race-neutral alternative that is likely to be raised in discussions of whether consideration of race is in fact necessary to achieve a university’s goals. Indeed, there is a growing body of medical and social science research exploring the need for and impact of cultural competence training for medical students and physicians as an intervention for implicit racial bias and differential treatment based on race. While such training may help ameliorate the harms caused by medical practitioners’ racial biases by

261. Sydney Lupkin, *Why America’s Minority Doctor Problem Begins in the Third Grade*, VICE NEWS (Mar. 16, 2016, 10:10 AM), <http://news.vice.com/article/why-are-there-so-few-minority-doctors-united-states> [<http://perma.cc/HSL3-APHK>].

262. Susan Svrluga, *The Number of Black Med Students Keeps Dropping. Here’s How to Change That.*, WASH. POST: GRADE POINT (Sept. 25, 2015), <http://www.washingtonpost.com/news/grade-point/wp/2015/09/25/the-number-of-black-med-students-keeps-dropping-heres-how-to-change-that> [<https://perma.cc/9UCD-BDDV>].

raising awareness of the existence of their bias and providing tools to help combat its impact on patient treatment, this intervention does not address the other side of the interactional dynamic—that is, the deeply rooted mistrust Black Americans have of a predominantly white institution that has subjected them to centuries of medical mistreatment. Given the long history and the extent of this abuse, it seems unlikely that cultural competence training would be a viable substitute for educating and training more Black doctors who not only may already possess culturally specific knowledge and skills, but naturally quell patients' fears about medical treatment through their presence alone.

E. Limitations

Even if the Court were to reject the race-neutral alternatives previously discussed as viable substitutes for a race-conscious admissions policy in medical schools, other limitations to the arguments asserted here should be addressed. First and foremost, the Court's concession that racial health disparities exist and/or are an indicator of flaws in the delivery of medical services to marginalized communities rests on its willingness to accept the empirical data presented in the record. The history of the Court with respect to the intersection of law, science, and inequality is inconsistent at best, and downright hostile at worst.²⁶³ A distinguishing characteristic of the data presented here, as compared to the statistical data analysis proffered in *McCleskey v. Kemp*, for example, is that the data is not being cited to *prove* a constitutional violation. In *McCleskey*, although the Court rejected the argument that statistics indicating racial disparities in the imposition of the death penalty demonstrated an equal protection violation, it acknowledged that the sentencing disparities were statistically significant.²⁶⁴ Similarly, in *Dukes v. Wal-Mart*, the Court rejected statistical evidence demonstrating pay and promotion disparities between male and female employees as basis for proof of Walmart's discriminatory employment practices.²⁶⁵ As in *McCleskey*, statistical data in *Dukes* was proffered for purposes of proving a violation.²⁶⁶ The empirical data on racial health disparities

263. Compare *McCleskey v. Kemp* 481 U.S. 279 (1987) (holding that Professor David Baldus's statistical study finding that the application of the death penalty in Georgia was related to the race of the victim did not present substantial evidence justifying reversal of the petitioner's conviction), with *Brown v. Board of Education*, 347 U.S. 483 (1954) (embracing a psychological study suggesting that school segregation caused harm to Black schoolchildren by instilling in them a sense of inferiority).

264. *McCleskey*, 481 U.S. at 324.

265. *Wal-Mart Stores v. Dukes*, 564 U.S. 338 (2011).

266. *Id.*

discussed at length throughout this piece is not intended to prove that Black patients have been subjected to an equal protection violation, or that race concordant doctors can remedy such a violation. In contrast, it is intended to highlight the poorer state of health experienced by Black Americans and suggest that an attenuated causal relationship between a shortage of Black doctors and the persistence of Black health disparities may exist.

Furthermore, the underlying motivation of the researchers who have collected empirical data on racial health disparities may also mitigate hostility towards the evidence during the judicial review. Data on racial health disparities and the impact of race concordance on patient experiences and outcomes emerged within the medical field and has largely been used to inform the development of interventions and policy recommendations within the practice of medicine. It is possible that the Court may infer that the original purpose of these studies lends them more legitimacy; in other words, it is unlikely these studies were developed or implemented with anticipation of affirmative action litigation in mind. As such, their claims should be trusted as wholly independent of any particular legal strategy, and therefore more reliable in their claims regarding challenges in the medical community.

Finally, the racial remediation theory proposed here asserts that the race of a service provider is a salient factor in the quality of how medical services are delivered to and perceived by members of the same racial group, which in turn impacts racial disparities in healthcare. To the extent that this theory posits the existence of a significant relationship between the race of a service provider and the perceptions of racially concordant consumers, there is a risk it will be conflated with “role model theory.”²⁶⁷ “Role model theory,” which was presented as the compelling governmental interest in *Wygant v. Jackson Board of Education*, is the notion that the presence of individuals of color in esteemed social and professional roles is a critical component to uplifting communities of color.²⁶⁸ By working in vocations that have historically been difficult for nonwhite people to access, the theory suggests, role models provide inspiration to communities of color and embody the existence of a colorblind meritocracy, where hard work is rewarded irrespective of one’s race.²⁶⁹

More broadly, the concept of the role model “transcends a specific role to include . . . [the] entire set of commitments, actions, and habits [that] will shape

267. See *Wygant v. Jackson Bd. of Educ.*, 476 U.S. 267, 274–76 (1986) (plurality opinion).

268. See *id.* at 274; Richard Delgado, *Affirmative Action as a Majoritarian Device: Or, Do You Really Want to Be a Role Model?*, 89 MICH. L. REV. 1222, 1226–27 (1991).

269. See Delgado, *supra* note 268, at 1223 n.5.

the attitudes and aspirations” of the youth.”²⁷⁰ This theory was subject to harsh criticism by the Court and critical race scholars alike, albeit on distinct grounds.²⁷¹ Writing for a plurality of the Court in *Wygant*, Justice Powell doubled down on his disdain for the concept of societal discrimination as too amorphous, insufficient, and over expansive a basis for a race-conscious remedy.²⁷² Moreover, the theory was dismissed as not bearing a direct relationship to the harm caused by past discriminatory hiring practices, as there were several explanations for disparities between the percentage of minority faculty and the percentage of minority students unrelated to discrimination.²⁷³ Powell went on to deride the role model theory of justification for its indefiniteness, expressing concerns that it had no logical ending point.²⁷⁴ Unpacking the theory from an entirely different vantage point, critical race theorist Richard Delgado lambasted the idea of a role model justification as unduly burdensome to the aspirational figure, as assimilationist, and as deceiving in its promotion of the meritocracy myth.²⁷⁵

The value of taking race into account in admissions to medical schools for purposes of remedying racial health disparities is readily distinguishable from taking account of race in any racial remediation context for the purpose of producing role models. The crux of the argument sketched out here is that Black doctors may possess racially and culturally specific knowledge, skills, and experiences that equip them to manage Black patients’ healthcare more effectively, and that Black patients may also be more trusting and, therefore, inclined to adhere to treatment if they are served by a doctor from the same racial background. The work that the racial identity of the doctor performs is the requisite trust- and relationship-building that leads to better health outcomes. The Black doctor’s presence does not merely serve the more arbitrary representative function that underlies role model theory, but rather serves a very explicit connective function that unites sick people with the medical treatment they need. The most critical aspect of the Black doctor’s role is not that she inspires others to become medical practitioners but that she fosters an environment of trust that drives medical treatment.

270. Adeno Addis, *Role Models and the Politics of Recognition*, 144 U. PA. L. REV. 1377, 1381 (1996).

271. See *Wygant*, 476 U.S. at 275–76; Addis, *supra* note 270, at 1446 n.194; Delgado, *supra* note 268.

272. *Wygant*, 476 U.S. at 276.

273. *Id.*

274. *Id.* at 275.

275. Delgado, *supra* note 268, at 1226–29.

The nature of the relationship is not the only distinguishable characteristic of the theory proposed herein. Justice Powell's concern that the theory of remediation in *Wygant* did not bear a direct relationship to the harm caused by past discriminatory practices is adequately addressed by the historicized analysis proffered here. The theory of racial remediation in the racial health disparities context pointedly links the history of racist medical experimentation and healthcare policy to contemporary racial health disparities and demonstrates how the evisceration of race-conscious remediation since the *Bakke* opinion has played a part in upholding the legacy of that racist history. In *Wygant*, Powell concluded his takedown of the Jackson Board of Education's hiring program by insisting that "the Board must ensure that, before it embarks on an affirmative action program, it has convincing evidence that remedial action is warranted. That is, it must have sufficient evidence to justify the conclusion that there has been prior discrimination." It would be a long shot to suggest that the history of racism in health illuminated here is not sufficient evidence to justify a conclusion of prior discrimination.

CONCLUSION

Disparities in Black health today reflect a devastating legacy of anti-Black racism in which the law has been complicit. Efforts to use affirmative action to remedy the effects of this legacy have been a fool's errand for four decades, as diversity's distractions have succeeded in diverting attention away from the contemporary effects of our racial past. The fortieth anniversary of *Bakke* presents an opportunity to reevaluate the narrative around racial remediation, particularly how limiting the discourse around diversity truly is, and how it leads us astray from the tangible injustices that impact the daily lives of racially subordinated groups. By no means is the argument presented here intended to be the end of this discussion. The identified relationship between racial disparities and racial inequity in access to higher education invites similar analyses of how other institutions reinforce historical disadvantage through race neutral policies. When law schools struggle to achieve racial diversity, their constrained efforts do not simply impact classroom dynamics—they produce a profession that incarcerates Black people at disparate rates and reinforce the racist nature of policies, practices, and institutions the Fourteenth Amendment was intended to eradicate, not safeguard.

Just as the story of racial disparities is not limited to any one institution, the significance of race-conscious remediation is not confined to one racial group. Native Americans, Latinx, and others share their own collective histories, which

manifest in disparate outcomes based on race. Taking account of race in admissions for these groups demands an investigation into how policies, practices, and institutions have caused them race-specific harm and compels recognition of a race-conscious intervention accordingly.