

1-1-1994

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Marianne L. Engelman Lado

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### Recommended Citation

Marianne L. Lado, *Breaking the Barriers of Access to Health Care: A Discussion of the Role of Civil Rights Litigation and the Relationship Between Burdens of Proof and the Experience of Denial*, 60 Brook. L. Rev. 239 (1994).

Available at: <https://brooklynworks.brooklaw.edu/blr/vol60/iss1/8>

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BREAKING THE BARRIERS OF ACCESS TO HEALTH CARE: A DISCUSSION OF THE ROLE OF CIVIL RIGHTS LITIGATION AND THE RELATIONSHIP BETWEEN BURDENS OF PROOF AND THE EXPERIENCE OF DENIAL

*Marianne L. Engelman Lado\**

INTRODUCTION

The delivery of health care in the United States is multi-tiered; the greatest levels of security and many of the benefits of medical research and advanced technology are reserved for selected segments of American society. Structural forms of racial discrimination and practices of segregation by providers of medical services are common and entrenched, and they ensure that such security and benefits are not available to many African Americans and most of the poor. Part I of this Article will focus on the need to ensure protection against racial discrimination in the delivery of health care. Part II will discuss the role of civil rights litigation in addressing barriers of access. Finally, Part III will turn to a key problem faced by civil rights litigators in the courts today—the gulf between the realities of exclusion that are experienced by our clients and what is accepted as proof of exclusion by courts. Unfortunately, advocates can expect this problem to survive even a dramatic overhaul of the health care regime. This Article suggests that to be more successful on behalf of our clients, we need to find more effective and creative ways of communicating the experience of denial.

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\* Staff Attorney for the NAACP Legal Defense & Educational Fund, Inc. ("LDF"). Portions of this paper are based on *NAACP Legal Defense & Educational Fund, Inc., Inequity in the Distribution of Health Care: Closing the Gap* (1992), a report that I authored in 1992 as a staff attorney at the LDF. My appreciation goes both to LDF for the opportunity to work on issues of access to health care, and to Alice Brown, John Charles Boger, Ronald L. Ellis, Jane Perkins and William King, all of whom assisted with the development of the report.

## I. BARRIERS OF ACCESS TO CARE

Despite the development of state and federal medical care programs over the past three decades,<sup>1</sup> as well as tremendous efforts by health care professionals working under adverse conditions in clinics and other health care facilities in low-income communities, health *status* remains largely dependent upon race and income. Indeed, from conception onward, African Americans, particularly the poor, are exposed to greater health risks than are whites,<sup>2</sup> and are more likely to contract preventable illness,<sup>3</sup> to suffer from chronic and often disabling

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<sup>1</sup> See, e.g., Subchapter XVIII of the Social Security Act, 42 U.S.C. § 1395 (1988 & Supp. III 1991) (Health Insurance for the Aged and Disabled); Subchapter XIX of the Social Security Act, 42 U.S.C. § 1396 (1988 & Supp. III 1991) (Grants to States for Medical Assistance Programs).

<sup>2</sup> See generally Wornic L. Reed et al., *The Health and Medical Care of African-Americans*, in ASSESSMENT OF THE STATUS OF AFRICAN AMERICANS 5 (1992) (discussing risks related to infant mortality, cancer incidence, homicide, lead poisoning, chemical dependency and AIDS). See also COMMITTEE FOR RACIAL JUSTICE, TOXIC WASTES AND RACE IN THE UNITED STATES: A NATIONAL REPORT ON THE RACIAL AND SOCIO-ECONOMIC CHARACTERISTICS OF COMMUNITIES WITH HAZARDOUS WASTE SITES (1987); ENVIRONMENTAL DEFENSE FUND, LEGACY OF LEAD: AMERICA'S CONTINUING EPIDEMIC OF CHILDHOOD LEAD POISONING 24 (1990) (reporting that almost 70% of inner-city children are estimated to be contaminated by detrimental levels of lead); U.S. BUREAU OF THE CENSUS, U.S. DEPT OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 133 (113th ed. 1993) (Table 200) (Children Immunized Against Specific Diseases, by Age Group: 1985 and 1991) (reporting that African American and other non-white children were less likely to have received diphtheria-tetanus-pertussis, polio, measles, or Hemophilus B vaccinations at two-years old and at one- to four-years old than were white children of the same age) [hereinafter STATISTICAL ABSTRACT].

<sup>3</sup> See U.S. DEPT OF HEALTH & HUMAN SERVS. ("HHS"), HEALTH STATUS OF MINORITIES AND LOW-INCOME GROUPS (3d ed. 1991) [hereinafter HEALTH STATUS]; HHS, REPORT OF THE SECRETARY'S TASK FORCE ON BLACK & MINORITY HEALTH (1985) [hereinafter SECRETARY'S TASK FORCE]; Reed et al., *supra* note 2; see also CENTERS FOR DISEASE CONTROL & PREVENTION, HIV/AIDS SURVEILLANCE REP., May 1993, at 11 (Table 8) (reporting AIDS cases by race/ethnicity); AMA Council on Ethical & Judicial Aff., *Black-White Disparities in Health Care*, 263 JAMA 2344 (1990) [hereinafter *Black-White Disparities*]; Lance B. Becker et al., *Racial Differences in the Incidence of Cardiac Arrest and Subsequent Survival*, 329 NEW ENG. J. MED. 600 (1993) (finding the incidence of cardiac arrest significantly higher for blacks than whites in every age group); Pat Braus, *Heart Disease*, AM. DEMOGRAPHICS 32, 34 (1990) (African Americans have higher rates of heart disease); Zev Harel, *Older Americans Act Related Homebound Aged: What Difference Does Racial Background Make?*, 9 J. GERONTOLOGICAL SOC. WORK 133 (1986) (compared with their white counterparts, the black aged are more impaired in health and functional status).

Although the discussion presented here reports primarily on the health status

conditions such as diabetes,<sup>4</sup> hypertension,<sup>5</sup> and cancer,<sup>6</sup> and to die prematurely.<sup>7</sup> Consider the following:

- African American infants are more than twice as likely

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and experiences of low-income African Americans, since this is the focus of the author's work, civil rights advocates who are working to address barriers of access in the provision of health care have strong opportunities for coalition building across ethnic lines. In particular, inequities in the distribution of health care services and health hazards also fall with greater weight on other low-income people of color. Relatively high rates of disease incidence and premature mortality, and low levels of medical treatment are also experienced by other racial and ethnic minorities. See generally SECRETARY'S TASK FORCE, *supra*; Council on Sci. Aff., *Hispanic Health in the United States*, 265 JAMA 248 (1991); Antonio L. Estrada et al., *Health Care Utilization Barriers Among Mexican Americans: Evidence from HHANES 1982-1984*, 80 AM. J. PUB. HEALTH 27 (1990); Eli Ginzberg, *Access to Health Care for Hispanics*, 265 JAMA 238 (1991); Sylvia Guendelman & Joan Schwalbe, *Medical Care Utilization by Hispanic Children: How Does It Differ from Black and White Peers?*, 24 MED. CARE 925 (1986); Julia M. Solis et al., *Acculturation, Access to Care, and Use of Preventive Services by Hispanics: Findings from HHANES 1982-1984*, 80 AM. J. PUB. HEALTH 11 (1990); Fernando M. Trevino et al., *Health Insurance Coverage and Utilization of Health Services by Mexican Americans, Mainland Puerto Ricans, and Cuban Americans*, 265 JAMA 233 (1991).

<sup>4</sup> SECRETARY'S TASK FORCE, *supra* note 3, at 150; Kenneth G. Manton et al., *Health Differentials Between Blacks and Whites: Recent Trends in Mortality and Morbidity*, in HEALTH POLICIES AND BLACK AMERICANS 169-71 (1989); see also STATISTICAL ABSTRACT, *supra* note 2, at 94 (Table 129) (Death Rates by Selected Causes and Age, 1970-1990); HEALTH STATUS, *supra* note 3, at 134 (Figure 1) (containing the mortality rate differential).

<sup>5</sup> U.S. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES: 1985 121 (111th ed. 1991) (Table 196) (Persons With Activity Limitation, by Selected Chronic Conditions); HEALTH STATUS, *supra* note 3, at 149; SECRETARY'S TASK FORCE, *supra* note 3, at 110; Manton, *supra* note 4, at 169-70.

<sup>6</sup> NATIONAL CANCER INST., CANCER AMONG BLACKS AND OTHER MINORITIES: STATISTICAL PROFILES (1986) (Pub. No. 86-2785) (among the major racial and ethnic groups represented in the United States, African Americans have the highest incidence for all cancers combined, the highest overall cancer mortality rates and, along with Native Americans, the least favorable overall survival rates); see also STATISTICAL ABSTRACT, *supra* note 2, at 94 (Table 129) (Death Rates, by Selected Causes and Age: 1970 to 1990); SECRETARY'S TASK FORCE, *supra* note 3, at 89, 91; Reed et al., *supra* note 2, at 33-41.

While whites showed increased survival rates during the 1970s, African Americans experienced a largely unchanged survival pattern. Moreover, racial disparities in survival rates were independent of the time of diagnosis, i.e., disparate survival rates were experienced for both early and late diagnoses. NATIONAL CANCER INST., *supra*, at 6; see also, STATISTICAL ABSTRACT, *supra* note 2, at 138 (Table 211) (Cancer—Estimated New Cases, 1992, and Survival Rates, 1974-76 to 1983-88).

<sup>7</sup> STATISTICAL ABSTRACT, *supra* note 2, at 85 (Table 116) (Selected Life Table Values: 1969 to 1990); SECRETARY'S TASK FORCE, *supra* note 3, at 89, 91 (the African American population experiences 60,000 "excess deaths" annually); Reed et al., *supra* note 2, at 5, 9-12.

as white infants to die before reaching their first birthday,<sup>8</sup>

- African American women are three times more likely to die in childbirth than white women;<sup>9</sup>
- The life expectancy for African American men is eight years shorter than for white men; and
- African American women have a life expectancy nearly six years shorter than white women.<sup>10</sup>

As these examples illustrate, in the United States race is a crucial factor in determining not only health status, but even length of life.

There can be no doubt that the disparity in health status reflects, in part, the widespread continuation of discriminatory and segregatory practices in the provision of medical services.<sup>11</sup> Diagnosis and treatment often are biased by race and

<sup>8</sup> STATISTICAL ABSTRACT, *supra* note 2, at 89 (Table 121) (Infant, Maternal, and Neonatal Mortality Rates, and Fetal Mortality Ratios, by Race: 1970-1990). See generally HHS, 6 REPORT OF THE SECRETARY'S TASK FORCE ON BLACK & MINORITY HEALTH: INFANT MORTALITY 16-20, 56 (1986); Reed et al., *supra* note 2, at 17-21.

<sup>9</sup> STATISTICAL ABSTRACT, *supra* note 2, at 89 (Table 121) (Infant, Maternal, and Neonatal Mortality Rates, and Fetal Mortality Ratios, by Race: 1970-1990) (reporting a maternal mortality rate in 1990 of 22.4 for African Americans and 5.4 for whites); see also W. Joseph May & Frank C. Greiss, Jr., *Maternal Mortality in North Carolina: A Forty-Year Experience*, 161 AM. J. OBSTETRICS & GYNECOLOGY 555 (1989); Reed et al., *supra* note 2, at 22; Carla J. Syverson et al., *Pregnancy-Related Mortality in New York City, 1980 to 1984: Causes of Death and Associated Risk Factors*, 164 AM. J. OBSTETRICS & GYNECOLOGY 603 (1991).

<sup>10</sup> STATISTICAL ABSTRACT, *supra* note 2, at 86 (Table 115) (Expectation of Life at Birth, 1970 to 1991, and Projections, 1995 to 2010) & (Table 117) (Expectation of Life and Expected Deaths, by Race, Sex and Age: 1990).

<sup>11</sup> For greater detail on discriminatory practices in the provision of medical services, see, e.g., *Black-White Disparities*, *supra* note 3, at 2345-46; Sandra Blakeslee, *Poor and Black Patients Slighted, Study Says*, N.Y. TIMES, Apr. 20, 1994, at B6 (reporting on two studies appearing in JAMA that found racial disparities in the delivery of care in hospitals); Sheana W. Funkhouser & Debra K. Moser, *Is Health Care Racist?*, 12 ADV. NURS. SCI. 47 (1990); David L. Wood et al., *Access to Medical Care for Children and Adolescents in the United States*, 86 PEDIATRICS 666 (1990) (survey research results show that poor, uninsured or non-white children less frequently have a regular source of care, more frequently use emergency rooms, community clinics and hospital outpatient departments as their regular providers, and more frequently encounter financial barriers to health care; moreover, independent of insurance or health status, low-income, nonwhite children have much less access to care than their higher-income, white counterparts); John Yergan et al., *Relationship Between Patient Race and Intensity of Hospital Services*, 25 MED. CARE 592 (1987); see also Mary Benedict et al., *Racial Difference in Health Care Utilization Among Children in Foster Care*, 11 CHILDREN & YOUTH

class. For example, studies have shown that older black men on Medicare receive heart bypass surgery about one-fourth as often as similarly situated whites. The gap is widest in the Southeast, where whites are more than six times more likely to have the surgery as blacks.<sup>12</sup> African Americans with kidney failure are less likely to receive long-term dialysis or kidney transplants.<sup>13</sup>

Segregation, racial discrimination and practices of exclusion have characterized the provision of medical care in the United States from its inception. As historian Rosemary Stevens writes, throughout the twentieth century “[h]ospitals, as social institutions, carried (and enhanced) prevailing assumptions about social class and racial divisions in the United States.”<sup>14</sup> African Americans in need of medical care were denied services entirely, or were placed in segregated wards that provided inferior care in the least desirable facilities.<sup>15</sup> Federal policy sanctioned segregation in federally assisted and federally administered facilities.<sup>16</sup>

SERV. REV. 285 (1989); Phyllis Solomon, *Racial Factors in Mental Health Service Utilization*, 11 PSYCHOSOCIAL REHAB. J. 3 (1988); Frederick D. Wolinsky et al., *Ethnic Differences in the Demand for Physician and Hospital Utilization Among Older Adults in Major American Cities: Conspicuous Evidence of Considerable Inequalities*, 67 MILBANK Q. 412 (1989).

<sup>12</sup> *Fewer Heart Bypasses for Blacks on Medicare*, N.Y. TIMES, Mar. 18, 1992, at B6; see also *Black-White Disparities*, *supra* note 3, at 2344-45; Braus, *supra* note 3, at 34 (African Americans are less likely to have coronary bypass and coronary angiography operations despite higher rates of heart disease); Mark B. Wanneker & Arnold M. Epstein, *Racial Inequalities in the Use of Procedures for Patients with Ischemic Heart Disease in Massachusetts*, 261 JAMA 253 (1989).

<sup>13</sup> *Black-White Disparities*, *supra* note 3, at 2355; see also Spencer Rich, *Study: Blacks Wait Longer for Kidney Transplants*, WALL ST. J., Aug. 23, 1990, at A16.

<sup>14</sup> ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY 50 (1989).

<sup>15</sup> *Id.* Stevens describes, for example, the availability of hospital care in the 1920s:

Pay beds for black Americans were largely nonexistent, and where they existed, in all-black hospitals, services were often poor and sometimes dangerous. Almost a quarter of all general hospitals in the United States in 1922 reported that they limited their services to ‘whites’ . . .

*Id.* at 137. See also the description of racial distinctions between and within hospitals throughout the twentieth century. *Id.* at 9-10, 112-13, 174, 252-54, 312; W. Montague Cobb, *Medical Care and the Plight of the Negro*, 54 CRISIS 201, 208-20 (1947); Funkhouser & Moser, *supra* note 11, at 48-49 (on relationship between history of racial conflict and health care access).

<sup>16</sup> For a discussion of inequality by race and class in Veterans Administration hospitals, see Stevens, *supra* note 14 at 127, 222, 386 n.49. Segregation in and

In *I Know Why the Caged Bird Sings*, Maya Angelou writes of her experience as a child in need of health care.<sup>17</sup> Her grandmother tried aspirin and home remedies to cure the author's toothache, and Maya Angelou tried prayers. "I lived a few days and nights in blinding pain," Angelou writes,

not so much toying with as seriously considering the idea of jumping in the well, and Momma decided I had to be taken to a dentist. The nearest Negro dentist was in Texarkana, twenty-five miles away, and I was certain that I'd be dead long before we reached half the distance.<sup>18</sup>

Her grandmother decided, against custom, to take her to a white dentist who lived in their town and to whom her grandmother had lent money during the Depression. Angelou describes bathing and putting on freshly starched and ironed clothes, making the trek to the white side of town, and proceeding with her grandmother to the back door of Dr. Lincoln's house. Dr. Lincoln, ignoring the little girl and her pain, refused to treat her, saying "my policy is I don't treat colored people."<sup>19</sup> Angelou's grandmother pleaded with him and reminded him that he owed her a favor. He replied, "My policy is I'd rather stick my hand in a dog's mouth than in a nigger's."<sup>20</sup>

During the 1970s, one elderly African American who was born in Lawrence County, North Carolina, described to an interviewer how the dearth of physicians available to African Americans in the first half of the twentieth century affected his family:

There wasn't too many colored doctors in the South. There was an old one named Dr. James. When my brothers was bein' all that sickly, all through the flu, you had to go 'bout ten miles to the little town and get him. Then he'd be out on a call, and he'd come the next day, or the day after. By the time he got there, everbody would

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discrimination by Hill-Burton facilities are also discussed. *Id.* at 219, 252-54 (Hill-Burton "allowed for 'equitable provision' to be made through separate but equal hospital facilities."). The "separate but equal" provision of the Hill-Burton Act was held unconstitutional in *Simkins v. Moses H. Cone Memorial Hosp.*, 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964); see also PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 350 (1982).

<sup>17</sup> MAYA ANGELOU, *I KNOW WHY THE CAGED BIRD SINGS* 157-60 (Bantam 1993) (1969).

<sup>18</sup> *Id.* at 157.

<sup>19</sup> *Id.* at 160.

<sup>20</sup> *Id.*

be dead and you'd be goin' to the funeral. . . . Didn't have no family doctors then, 'cause you couldn't afford it. . . .<sup>21</sup>

The speaker does not even mention a visit to a white doctor as a possibility.<sup>22</sup>

As Stevens suggests, "Formal desegregation of hospitals, North and South, was not achieved until the middle and late 1960s, under the double force of the Civil Rights Act of 1964 and the Medicare legislation of 1965."<sup>23</sup> Today, "informal" practices of racial discrimination continue, and health facilities remain, for the most part, segregated, largely on the basis of economic status, which is highly correlated to race.<sup>24</sup> Physicians, private hospitals and private nursing homes all insulate themselves from the perceived burdens of serving patients who do not offer high reimbursement or prestige.<sup>25</sup> Indeed, it re-

<sup>21</sup> WHEN I WAS COMIN' UP: AN ORAL HISTORY OF AGED BLACKS 158 (Olsen Faulkner et al., eds., 1982).

<sup>22</sup> See also Zora Neale Hurston, *My Most Humiliating Jim Crow Experience*, in TRIALS, TRIBULATIONS, AND CELEBRATIONS: AFRICAN-AMERICAN PERSPECTIVES ON HEALTH, ILLNESS, AGING AND LOSS 23-24 (Marian Gray Secundy ed., 1992) (story of discrimination by a white physician in the North).

<sup>23</sup> STEVENS, *supra* note 14, at 50; see also DIETRICH C. RIETZES, NEGROES AND MEDICINE (1958). Significantly, not until 1964, when the Supreme Court denied certiorari in *Simkins v. Moses H. Cone Memorial Hosp.*, 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964), was the "separate but equal" provision of the Hill-Burton Act, 42 U.S.C. § 291e(f) (1958), held unconstitutional.

<sup>24</sup> See, e.g., STEVENS, *supra* note 14, at 50, 312; *Hospital Keeps Private, Medicaid Patients Separate, Paper Reports*, AP NAT'L DESK, Oct. 19, 1993 (reporting on a series of five articles by Annette Fuentes, DAILY NEWS, Oct. 18-22, 1993) [hereinafter *Medicaid Patients*]; Kevin Sack, *Inquiry Finds Hospital Had Two Categories*, N.Y. TIMES, Apr. 30, 1994, at 25.

Regarding the sociodemographic context for racial disparities, see generally, Reed et al., *supra* note 2, at 1-5 (African Americans are more than three times more likely to have incomes below the poverty level as whites); STATISTICAL ABSTRACT, *supra* note 2, at 468 (Table 733) (Income Per Capita, by Race for States: 1989) (in 1989, per capita income for whites equalled \$15,687; for Blacks, \$8859; for Hispanics, \$8400) and 469 (Table 735) (Persons Below Poverty Level and Below 125 Percent of Poverty Level: 1959 to 1991) (in 1991, 11.3% of whites had incomes below the poverty level, as compared to 32.7% of Blacks and 28.7% of Hispanics).

<sup>25</sup> Higher percentages of African Americans under the age of 65 than whites are either uninsured or insured through the Medicaid program. STATISTICAL ABSTRACT, *supra* note 2, at 115 (Table 165) (Health Insurance Coverage Status, by Selected Characteristics: 1985 to 1991), (Table 166) (Health Insurance Coverage, by Selected Characteristic: 1987-89) & 116 (Table 167) (Persons Without Health Insurance Coverage, by Selected Characteristic: 1989). For a discussion of the impact of participating in the Medicaid program on the availability of services, see Robert Pear, *Low Medicaid Fees Seen as Depriving the Poor of Care*, N.Y. TIMES, Apr. 2, 1991, at A1; Physician Payment Review Commission, *Annual Report to Congress*

mains commonplace for medical practitioners to limit their practices to privately insured patients. Low-income African Americans who are able to obtain care from private practitioners and private facilities often are relegated to separate wings or provided with an inferior level of service.<sup>26</sup> As Charles Lawrence has written, "[W]hile formal, legally sanctioned segregation was the chief form of stigmatization prior to *Brown* and the Civil Rights Act of 1964 . . . the system has yet to be dismantled, and other stigmatizing mechanisms . . . have reinforced its effects."<sup>27</sup>

In a meeting not long ago with tenants of a public housing complex in New York, words heard by the author illustrated both the experiences of the speakers and the utter alienation so many people feel from the health care system:

Residents spoke of chaos in the emergency room of a not-for-profit hospital located nearby: One woman, Mrs. C, knew a neighbor who suffered with the effects of cancer and, yet, had lain in the emergency room for days. He was told that there were no beds for him.

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274 (1991) ("Medicaid directors were asked whether low physician participation was a problem. . . . [Forty-four] states identified participation problems, and more than half (twenty-seven) identified problems with both geographic and specialty distribution of participating physicians."); see also Jane Perkins, *Increasing Provider Participation in the Medicaid Program: Is There a Doctor in the House?* 26 HOUS. L. REV. 77 (1989); Beth K. Yudkowsky et al., *Pediatrician Participation in Medicaid: 1978 to 1989*, 85 PEDIATRICS 567 (1990) (between 1978 and 1989, the proportions of both pediatricians who would not care for children on Medicaid and those who placed quotas on their Medicaid patient load increased). Even in states such as New York, where Medicaid reimbursements for inpatient care have been set at the same level as those set by private insurers such as Blue Cross, practices of exclusion and discrimination occur in the provision of both physicians' and hospital services. Facilities cater to the practices of attending physicians and to the perception that private pay patients would not want to share a room or corridor with patients from different socioeconomic backgrounds.

<sup>26</sup> See STEVENS, *supra* note 14, at 48-49, 112-13, 336; Yergan et al., *supra* note 11; see also Sack, *supra* note 24, at 25; *Medicaid Patients*, *supra* note 24, at 12.

<sup>27</sup> Charles R. Lawrence III, *The Id, the Ego, and Equal Protection, Reckoning with Unconscious Racism*, 39 STAN. L. REV. 317, 351 & n.151 (1987). Derrick Bell adds

[T]he *Brown* decision invalidated 'separate but equal,' replacing it—as civil rights advocates urged—with 'equal opportunity.' But given the continued motivations for racism, the society has managed to discriminate against blacks as effectively under the remedy as under the prior law—more effectively really, because discrimination today is covert, harder to prove, its ill effects easier to blame on its black victims.

DERRICK BELL, *FACES AT THE BOTTOM OF THE WELL: THE PERMANENCE OF RACISM* 104 (1992).

Mrs. C. also knew a young girl who went to the emergency room ill; after a wait, the girl was sent back home, where she died.

Residents spoke of racial and economic segregation at the local not-for-profit: the hospital put the rich in one wing and the poor, including people with Medicaid, in another. The hospital's staff treated their two categories of patients differently. For example, the hospital would not move poor patients out of the emergency room into beds that were available in the "private" wing. Moreover, the conditions in the private and public wings contrasted sharply. The public wings, or poor people's wards, were "different worlds." Residents spoke of inferior food and a lack of privacy. They had seen feces in open areas. In the public ward, they stated, patients did not get their beds changed as often or often enough. In the public ward, patients did not get their medicine on time. A young father of four, Mr. E., spoke about his stays in the public and private wings. In the public ward, his IV bag would empty and no one would change it until hours later. He watched other patients and learned how to shut off the IV himself. If a patient were in pain and asked for Tylenol, hospital staff would not give the patient the medication and, instead, would say that he had to wait until the next morning. In the private units, by contrast, appropriate medicines were listed on the charts and patients were able to get pain killers right away. Mr. S., who had also stayed on both wings, stated that physicians had different attitudes in the private wing and that nurses there provided more attention. Mr. S. stated that he felt badly when he left his bed in the private unit, because on his way out he had passed a number of poor people in need of beds—including someone with appendicitis. He knew that there were beds for insured people but not for the people he saw in the emergency room.

Simple lack of money was also an issue. As a result of a robbery, Mr. S. had to have an eye operation. When he was ready to leave the hospital, he found that the cost of the medicines that he was supposed to take at home were \$96 and \$76. He could not afford them. He asked if he could have some just for one day. Hospital staff said that they didn't have any to give him. Other residents recalled how they had been told to go to the public hospital if they wanted free care. They recounted being told that they needed money to pay for hospital services at outpatient clinics and even for emergency room services. Mr. S. stated that when he did not have the \$72 that the hospital required to take out his stitches, he took the stitches out himself.

Given this treatment at the private, not-for-profit hospitals, why not go to the nearby municipal hospital? More than one resident recounted how they had heard of a person who had been "displaced" there for a few days. They pointed out that the public hospital was understaffed and overcrowded.<sup>28</sup>

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<sup>28</sup> Meeting in Manhattan Residence Between Attorneys Retained in *Mussington*

For at least the last fifteen years, many private facilities have used specific, identifiable tactics to avoid treating poor people of color altogether or limiting their numbers. Some of these tactics are "structural"; that is, designed to or with the effect of limiting access for the poor and, disproportionately, people of color. Medical practices or facilities are set up, or structured,<sup>29</sup> so as to erect barriers to entry. Such actions preclude the need for making further discriminatory determinations to exclude people of color on an individual basis. These structural decisions can sometimes be explained as motivated on another basis, but exclusion or change in patient "mix" is at least part of the reason for the action.<sup>30</sup> For example, some facilities relocate from African American or Latino communities to predominantly white, suburban communities.<sup>31</sup> Other

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*v. St. Luke's Roosevelt Hospital Center and Tenants of New York City Public Housing* (Aug. 27, 1991) (names were changed for reasons of confidentiality) [hereinafter Meeting in Manhattan Residence]. See *infra* section III.A. for a discussion of *Mussington v. St. Luke's Roosevelt Hosp. Ctr.*, No. CIV.92-89618 (S.D.N.Y. filed Dec. 11, 1992).

<sup>29</sup> The word "structured", as used here, is specifically defined as concerned with something built or arranged in a definite pattern of organization. See WEBSTER'S NEW COLLEGIATE DICTIONARY 1154 (G. & C. Merriam Company 1977) (definitions of "structural" and "structure").

<sup>30</sup> Evidence of discriminatory intent is not required to prove racial discrimination pursuant to Title VI of the Civil Rights Act of 1964, provided that discriminatory impact is prohibited by agency regulations. *Guardians Ass'n v. Civil Serv. Comm'n of New York*, 463 U.S. 582 (1983); see also *Alexander v. Choate*, 469 U.S. 287, 293-94 (1985).

Although decisions to structure facilities in ways that limit access to poor people of color are often intentional, the search for sufficient evidence to prove this "intent" in court may be illusory. As one court stated, "[A] requirement that the plaintiff prove discriminatory intent . . . is often a burden that is impossible to satisfy. "[I]ntent, motive, and purpose are elusive subjective concepts." *Metro-politan Hous. Dev. Corp. v. Village of Arlington Heights*, 558 F.2d 1283, 1290 (7th Cir. 1977) (quoting *Hawkings v. Town of Shaw*, 461 F.2d 1171, 1172 (5th Cir. 1972) (en banc) (per curiam), cert. denied, 434 U.S. 1025 (1978)), cert. denied, 434 U.S. 1025 (1978); see also *Lawrence III*, *supra* note 27, at 354-55 (advocating the admission of proof of unconscious racism as evidence of intent).

<sup>31</sup> Mitchell F. Rice, *Inner-City Hospital Closures/Relocations: Race, Income Status, and Legal Issues*, 24 SOC. SCI. MED. 889 (1987); see Alan Sagar, *The Closure of Hospitals that Serve the Poor: Implications for Health Planning 2* (Apr. 30, 1982) (statement to the Subcommittee on Health and the Environment) (likelihood of hospital closure is directly related to the percentage of African Americans in the community) (on file with author); see also *NAACP v. Wilmington Med. Ctr.*, 689 F.2d 1161, 1163-64 (3d Cir. 1982) (providing case history of civil rights lawsuit challenging relocation of services); *Terry v. Methodist Hosp. of Gary*, Nos. H-76-373 & H-77-154 (N.D. Ind. July 17, 1979) (consent decree).

facilities close or move the typical paths of entry for poor people—emergency rooms and obstetrical care units.<sup>32</sup> The privatization of public and not-for-profit health facilities is another technique for excluding the poor.<sup>33</sup> And still other facilities adopt restrictive hospital admissions policies,<sup>34</sup> limit the size of their emergency room, or simply refuse to admit poor people of color as a general practice, “dumping” lower income patients on other facilities.<sup>35</sup> One survey conducted in Chicago showed that of patients transferred from emergency rooms at private hospitals to the local public hospital, a grossly disproportionate percentage were poor people of color.<sup>36</sup> Private nursing homes

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<sup>32</sup> See, e.g., *Mussington v. St. Luke's Roosevelt Hosp. Ctr.*, No. CIV.92-89618 (S.D.N.Y. filed Dec. 11, 1992) (complaint) (regarding closure of obstetric and pediatric units), 824 F. Supp. 427 (S.D.N.Y. 1993), *aff'd*, 18 F.3d 1033 (2d Cir. 1994), discussed below.

<sup>33</sup> See Woodrow Jones & Patrick Clifford, *The Privatization of Treatment Services for Alcohol Abusers: Effect on the Black Community*, 82 J. NAT'L MED. ASS'N 337 (1990); see also Cassandra Q. Butts, *The Color of Money: Barriers to Access to Private Health Care Facilities for African-Americans*, 26 CLEARINGHOUSE REV. 159, 161-62 (1992).

<sup>34</sup> See 42 C.F.R. § 124.603(d) (1993) (Hill-Burton community service regulations that provide examples of admissions policies that may have the effect of excluding persons on impermissible grounds, including, for example: (1) the practice of restricting admissions to those patients who are referred by physicians with staff privileges, if area residents of low income are unable to gain admission as a result; (2) the practice of restricting admissions to those patients who are referred by physicians with staff privileges, if few or none of such physicians will treat Medicaid patients and the effect is to exclude Medicaid patients from the facility or from any service of the facility; (3) the practice of requiring an advance deposit before admitting or serving patients, if the effect is to deny admission to some persons or to cause them delay).

<sup>35</sup> See, e.g., Geraldine Dallek & Judith Waxman, “Patient Dumping” A Crisis in Emergency Medical Care for the Indigent, 19 CLEARINGHOUSE REV. 1413 (1986).

<sup>36</sup> Robert L. Schiff et al., *Transfers to a Public Hospital: A Prospective Study of 467 Patients*, 314 NEW ENG. J. OF MED. 552 (1986); see also Equal Access to Health Care: Patient Dumping, Thirty-Seventh Report by the Comm. on Government Operations, 100th Cong., 2d Sess. (1988); Equal Access to Health Care: Patient Dumping, Hearing Before the Subcomm. on Human Resources and Intergovernmental Relations, 100th Cong., 1st Sess. (1987); Arthur Kellermann & Bela Hackman, *Patient ‘Dumping’ in Tennessee: An Analysis of Emergency Department Transfers to the Regional Medicine Center at Memphis* (Oct. 4, 1986) (preliminary report submitted to the Board for Licensing Health Care Facilities, Tenn. Dept of Health & Env't) (revised Oct. 7, 1986); David A. Ansell & Robert L. Schiff, *Patient Dumping: Status, Implications, and Policy Recommendations*, 257 JAMA 1500 (1987); Emily Friedman, *Problems Plaguing Public Hospitals: Uninsured Patient Transfers, Tight Funds, Mismanagement, and Misperception*, 257 JAMA 1850 (1987); Larry S. Gage & Dennis P. Andrulis, *Our Nation's Great Public Hospitals*, 257 JAMA 1942 (1987).

are particularly noteworthy for their exclusionary policies. They properly have been described as the most segregated of the country's publicly licensed health care facilities.<sup>37</sup>

Lack of access to private and not-for-profit health care facilities—hospitals, nursing homes and the offices of health care practitioners—detrimentally affects the health of low-income African Americans in a number of ways: first, by directly limiting medical services; second, by increasing feelings of alienation; and third, by shifting the economic burden of treating the poor to often overcrowded and underfinanced clinics, municipal hospitals and emergency rooms.<sup>38</sup> Indeed, one ma-

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<sup>37</sup> See DAVID B. SMITH, DISCRIMINATION IN ACCESS TO NURSING HOMES IN PENNSYLVANIA (1991). African Americans represent 23% of the elderly poor but receive only 9% of the skilled nursing facilities care reimbursed by Medicaid. If the provision of nursing home services reflected medical need, African Americans would receive more, not less, care than whites. U.S. BUREAU OF THE CENSUS, U.S. DEPT OF COMMERCE, 1989 Series P-60, No. 168 CURRENT POPULATION REPORTS, CONSUMER INCOME: MONEY INCOME AND POVERTY STATUS IN THE UNITED STATES (Nov. 1990); HEALTH CARE FINANCING ADMIN. ET AL., STATISTICAL REPORT ON MEDICAL CARE: ELIGIBLES, RECIPIENTS, PAYMENTS, AND SERVICES, FY 90 (1991); see also NEW YORK STATE DIV. OF HUMAN RIGHTS ET AL., NEW YORK STATE NURSING HOME TASK FORCE FINAL REPORT (1986); ROSSY-MILLAN, AN ANALYSIS OF THE RELATION BETWEEN QUALITY OF CARE AND RACIAL SEGREGATION IN NEW YORK CITY'S NURSING HOMES (1987).

Moreover, as indicated above, low-income African Americans who are able to obtain care from private practitioners and private facilities are often relegated to separate wings or provided with an inferior level of service. See, e.g., STEVENS, *supra* note 14, at 48-49, 112-13, 336 (1989); Yergan et al., *supra* note 11.

<sup>38</sup> See Andrew B. Bindman et al., *Consequences of Queuing for Care at a Public Hospital Emergency Department*, 266 JAMA 1091 (1991) (finding that long queues for emergency care jeopardized the health of some patients); see also David W. Baker et al., *Patients Who Leave a Public Hospital Emergency Department Without Being Seen by a Physician: Causes and Consequences*, 266 JAMA 1085 (1991).

Significantly, the private health care system's neglect of the poor does not simply narrow the available sources for care; it shifts the economic burden of treating the uninsured and underinsured onto those clinics, public health facilities, and private facilities that do leave their doors open—and these institutions can ill afford the full weight of the economic burden. As a result, people using clinics and public facilities experience longer waits, overcrowding, and staff and equipment shortages. See NATIONAL ASS'N OF PUBLIC HOSPITALS, AMERICA'S SAFETY NET HOSPITALS: THE FOUNDATION OF OUR NATION'S HEALTH SYSTEM (1991); Dennis P. Andrulis et al., *Emergency Departments and Crowding in United States Teaching Hospitals*, 20 ANNALS EMERGENCY MED. 980 (1991); Lisa Belkin, *Why Emergency Rooms are on the Critical List*, N.Y. TIMES, Oct. 6, 1991, at E6; Howard W. French, *Harlem Hospital Overflows With Patients*, N.Y. TIMES, Jan. 5, 1990, at B1 (as private hospitals try to cut services and costs, crowding intensifies at public hospitals: "Kids who were once seen at other hospitals are now coming to Har-

major reason why African Americans are in comparatively poor health is that they cannot find health service providers that will care for them.<sup>39</sup>

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lem . . . because they know we will treat them and give them medications whether or not they have insurance.”).

See also STATISTICAL ABSTRACT, *supra* note 2, at 120 (Table 175) (Physician Contacts, by Place of Contact and Selected Patient Characteristic: 1990); Reed et al., *supra* note 2, at 113-39 (reporting that (a) only 52% of survey respondents who are uninsured or on Medicaid cite a physician's office as their usual place of care; (b) African Americans are more likely to be uninsured or on Medicaid; (c) more than 20% of physician contacts made by African Americans occur in hospital clinics or emergency rooms, compared to fewer than 12% by whites; (d) the average waiting time to see a physician is considerably longer for nonwhites than for whites; and (e) the rate of dissatisfaction with care received reported by African Americans is one and one-half to two times greater than the rate of dissatisfaction reported by whites).

<sup>39</sup> See Reed et al., *supra* note 2, at 138; C. K. Riessman, *The Use of Health Services by the Poor*, SOC. POL'Y, May/June 1974, at 41 (reporting that African Americans and the poor underutilize medical services but that evidence suggests increased utilization occurs when services are made available and structural barriers are removed or minimized); see also Arthur B. Bindman et al., *Public Hospital Closes: The Impact on Patients' Access to Care and Health Status*, 264 JAMA 2899 (1990) (finding that the closure of a public hospital had a significant effect on access to care and was associated with a decline in health status); Arthur L. Kellermann, *Too Sick to Wait*, 266 JAMA 1123 (1991).

The shortage of providers serving low-income communities of color is related, in part, to the limited number of health professionals who are persons of color. African American physicians, nurses and technicians tend to practice in medically underserved communities but are in short supply, a situation that is but another vestige of this country's history of discrimination and segregation. For a historical perspective on the shortage, see W. Montague Cobb, *Progress and Portents for the Negro in Medicine*, 55 CRISIS 107 (1948). For information and analysis of the low numbers of minority health professionals, see HHS, *Minorities & Women in the Health Fields*, HRSA-P-DV 90-3 at 17 (1990) (Table 3) (Estimated Active Supply of Selected Health Personnel According to Race/Ethnicity, Latest Year Available); W. Michael Byrd, *The Black Physician: History and Current Issues* (Apr. 5-7, 1990) (address before the Black Health: Historical Perspectives and Current Problems conference, Univ. of Wisconsin) (on file with author); W. Michael Byrd et al., *African-American Physicians' Views on Health Reform: Results of a Survey*, 86 J. NAT'L MED. ASS'N 191 (1994) (reporting that more than 90% of respondent physicians believed African Americans were discriminated against in the peer review process, malpractice settlements, the grant of practice privileges at hospitals, hospital staff promotions and in the referral practices of their white colleagues); Clint C. Wilson, *Minorities and the Medical Profession: A Historical Perspective and Analysis of Current and Future Trends*, 78 J. NAT'L MED. ASS'N 177 (1986).

For discussion of the tendency of African American health professionals to practice in medically underserved areas, see ASSOCIATION OF AMERICAN MEDICAL COLLEGES, *MINORITY STUDENTS IN MEDICAL EDUCATION* 16 (1988); David S. Guzick & Rene I. Jahiel, *Distribution of Private Practice Offices of Physicians with Specified Characteristics Among Urban Neighborhoods*, 14 MED. CARE 469 (1976); see also Stephen N. Keith et al., *Effects of Affirmative Action in Medical Schools: A*

This situation is worsening. Since 1980, access to care has actually declined for African Americans.<sup>40</sup> This decline has occurred in part because private facilities avoid treating African American patients whom they *perceive* as potential revenue losses.<sup>41</sup> Moreover, many of these facilities have concluded that they can better compete for more affluent, white patients if their other patients are also white.<sup>42</sup>

## II. THE ROLE OF CIVIL RIGHTS LITIGATION

So what can be done? Specifically, what roles can civil rights advocates play on behalf of their clients to address inequalities in the provision of health services? Clearly, the time has arrived for an overhaul of the health care system. During the legislative process, Congress must address issues of access, including how the President's Health Security Act and other legislative proposals deal with the inadequate number of health professionals and facilities that provide care in poor areas, and what protection each measure offers against racial discrimination. Advocates must find ways of helping their clients play a role in shaping the law and, also, participate in the process themselves.

Significantly, while a number of the proposals currently on the table promise to bring about major improvements in the nation's health delivery system, none would put an end to the segregation, racial discrimination, or policies and practices of exclusion that have characterized the provision of medical care in the United States from its inception.<sup>43</sup> As Derrick Bell cau-

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*Study of the Class of 1975*, 313 NEW ENG. J. MED. 1519 (1985).

<sup>40</sup> See, e.g., Mark J. Schlesinger, *Paying the Price: Medical Care, Minorities, and the Newly Competitive Health Care System*, 65 MILBANK Q. 270, 279 (Supp. II 1987); see also Gregory Pappas et al., *The Increasing Disparity in Mortality Between Socioeconomic Groups in the United States, 1960 and 1986*, 329 NEW ENG. J. MED. 103 (1993); Elisabeth Rosenthal, *Health Problems of Inner City Poor Reach Crisis Point*, N.Y. TIMES, Dec. 24, 1990, at A1.

<sup>41</sup> STEVENS, *supra* note 14, at 347; see also Laura M. Rosenthal, *Health Coverage for the Uninsured: A Primer for Legal Services Advocates*, 24 CLEARINGHOUSE REV. 1250, 1250-51 (1991); *supra* note 25 and accompanying text.

<sup>42</sup> Schlesinger, *supra* note 40, at 270-76.

<sup>43</sup> For a fuller discussion of issues that should be considered when evaluating current proposals, see NAACP Legal Defense & Educational Fund, Inc., *Testimony on the Health Security Act of 1992* (Nov. 16, 1993) (before the House Subcomm. on Commerce, Consumer Protection and Competitiveness of the Committee on

tions us, we must acknowledge the fact that "racism is a permanent component of American life."<sup>44</sup> And, to the extent that the reform packages retain divisions in the financing and delivery of services between the employed and the unemployed, or between the employed and those on public assistance—divisions that correspond to strata in our society—advocacy, including litigation, targeted at structural forms of discrimination will continue to be crucial.

Most generally, litigation can play a critical role in challenging practices that result in an unjust distribution of health services. Ironically, the sheer number of laws on the books suggest that poor people should already have adequate access to health care facilities. Many of the exclusionary policies and practices employed today are illegal and remediable. Indeed, civil rights statutes and equal access laws expressly prohibit discrimination on the basis of race<sup>45</sup> and, in some cases, payor status.<sup>46</sup> These statutes place affirmative obligations on the states not only to enforce civil rights laws but to ensure access to health care for Medicaid participants.<sup>47</sup> Unfortunately,

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Energy and Commerce) (on file with author).

<sup>44</sup> BELL, *supra* note 27, at 13. Bell also writes, "We must acknowledge [the permanence of racism,] not as a sign of submission, but as an act of ultimate defiance." *Id.* at 12.

<sup>45</sup> See, e.g., Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d (1982). See also 42 U.S.C. § 1981 (1988 & Supp. IV 1993), which guarantees the right "to make and enforce contracts" on a nondiscriminatory basis. Section 1981 applies to both public and private acts of discrimination, *Runyan v. McCrary*, 427 U.S. 160 (1976), and, unlike Title VI, its application is not limited to recipients of federal financial assistance. Section 1981 covers both racially based refusals to enter contracts and discriminatory actions affecting the terms and conditions of contractual relationships. 42 U.S.C. § 1981(b) (1988), *as amended* by the Civil Rights Act of 1991, Pub. L. No. 102-166, 105 Stat. 1071. Section 1981 claims may, thus, be brought to challenge a wide range of discriminatory practices, such as refusals by physicians to accept African American patients and segregation within health care facilities.

<sup>46</sup> See, e.g., 42 U.S.C. § 291c(e)(1) (1988) and 42 C.F.R. § 124.603(a), (c), (d) (1993) for a description of the Hill-Burton Act community service obligation, which prohibits Hill-Burton facilities from both discriminating against Medicaid and Medicare participants and employing restrictive admissions practices that exclude the poorer members of their communities. See also 42 U.S.C. § 1395dd (1988) (anti-dumping provision).

<sup>47</sup> See 42 U.S.C. § 1396a(a)(30)(A) (1982). For a specific example of litigation brought pursuant to these obligations, see *Matthews v. Coye*, C-90-3620-EFL (N.D. Ca. 1991) (a discussion of the case is available in NAACP LEGAL DEFENSE AND EDUCATIONAL FUND, INC., *INEQUITY IN THE DISTRIBUTION OF HEALTH CARE: CLOSING THE GAP* 57-64 (1992) (on file with the author)).

these statutes are not being enforced with any regularity, as the federal government and the states routinely fail to take enforcement action. Fortunately, however, most of these statutes permit private plaintiffs to bring lawsuits to challenge barriers of access to services for the poor.<sup>48</sup> It is *part of* the lawyer's job to press for enforcement of the law and, where necessary, to litigate.<sup>49</sup>

Lawsuits have at least three interrelated purposes. First, and, perhaps most importantly, as individual challenges to discriminatory or exclusionary practices, lawsuits bring relief to a plaintiff or group of plaintiffs.

Second, suits build a record of discriminatory and exclusionary practices, a record that can be used by advocates to educate the public and to support legislative and administrative change.<sup>50</sup> This function requires lawyers to listen

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<sup>48</sup> See, e.g., *Guardians Ass'n v. Civil Serv. Comm'n of New York*, 463 U.S. 582, 593-95 (1983) (private cause of action under Title VI); cf. *Franklin v. Gwinnett County Pub. Sch.*, 112 S. Ct. 1028 (1992) (analysis of private right of action under Title IX of the Education Amendments of 1972, which has developed along lines similar to Title VI); *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990) (implied right of action to enforce requirements of Boren Amendment to Medicaid Act). Despite the recent trend away from recognition of implied rights of action, see, e.g., *Suter v. Artist M.*, 112 S. Ct. 1360 (1992) (no implied right of action for private enforcement of the Adoption Assistance and Child Welfare Act of 1980), the Supreme Court has left standing private rights of action under both Title VI and the Boren Amendment, expressly choosing not to revisit its earlier decisions as to these statutes. *Id.* at 1363-67; *Franklin*, 112 S. Ct. at 1031. But see Rand E. Rosenblatt, *The Courts, Health Care Reform, and the Reconstruction of American Social Legislation*, 18 J. HEALTH POL. POLY & LAW 439 (1993) (discussing erosion of judicial rights enforcement role).

<sup>49</sup> Greater enforcement efforts are currently needed, for example, to end racial discrimination by hospitals, nursing homes and health care practitioners, pursuant to Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d (1982), among other statutes; to enforce the community service obligation of the Hill-Burton Act, see 42 U.S.C. § 291c(e)(1), 42 C.F.R. § 124.601 (1993); to ensure that low-income African Americans have access to appropriate emergency care, pursuant to 42 U.S.C. § 291c(e)(1), 42 C.F.R. § 124.603(b), and the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd; and to ensure that states are meeting their current responsibilities to secure access to services for Medicaid participants, see, e.g., 42 U.S.C. 1396a(a)(30)(A).

<sup>50</sup> As Cornel West has argued, legal work can play a significant role in educating the public on the fundamental principles and workings of our political arrangements. Such legal work constitutes "one of few buffers against cultural conservatism that recasts the law in its own racist . . . image"; it "helps keep alive memory traces left by past progressive movements of resistance"; and it serves "as a basis for the next wave of radical action." Cornel West, *The Role of Law in Progressive Politics*, 43 VAND. L. REV. 1797, 1799-1800 (1990).

carefully to their clients and, then, to use their legal skills to make the stories public.<sup>51</sup>

Third, collectively, these suits constitute a direct assault on the wall separating care for individuals of different racial or ethnic backgrounds and different income levels. This third point, in essence, suggests that enforcement of civil rights and access-oriented laws will help to undermine the viability of the current separation between the high-tech, quality care that wealthy, middle-class and predominantly white America has come to expect and the under-financed, inadequate and delayed health services so often provided to the poor and many people of color. Such litigation will contribute to a more equitable spread of the economic burden of serving the poor, thus adding to the already mounting pressure for change.

This approach to litigation is, in a sense, a descendant and an adaptation of the law reform model developed by Charles Hamilton Houston and Thurgood Marshall to challenge segregation in the 1930s, 1940s and early 1950s.<sup>52</sup> These legal pioneers developed a record of cases that challenged unequal conditions experienced by African Americans as violative of the law, pursuant to the "separate but equal" doctrine of *Plessy v. Ferguson*.<sup>53</sup> By so doing, they sought to undermine the basis for and legality of the prevailing doctrine. The strategy, together with changing mores and societal pressure, forced the Supreme Court to address the fundamental inequity of segregation and to bring its interpretation of the Constitution in line with a morality of human equality.

Unlike the effort that led to *Brown v. Board of Education*,<sup>54</sup> however, the stream of litigation addressing inequality in access to health care does not flow directly to the Supreme

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<sup>51</sup> As with any job of translation, the role of an attorney in rendering grievances and words into legal narrative is necessarily fraught with danger. For discussion of the role of the lawyer as translator in the context of criminal law, see Clark D. Cunningham, *The Lawyer as Translator, Representation as Text: Towards an Ethnography of Legal Discourse*, 77 CORNELL L. REV. 1298 (1992). As James Boyd White wrote in his review of Cunningham's article, "Translation is always imperfect; but it is necessary that it be done." James B. White, *Translation as a Mode of Thought*, 77 CORNELL L. REV. 1388, 1397 (1992).

<sup>52</sup> See generally RICHARD KLUGER, *SIMPLE JUSTICE: THE HISTORY OF BROWN V. BOARD OF EDUCATION AND BLACK AMERICA'S STRUGGLE FOR EQUALITY* (1975).

<sup>53</sup> 163 U.S. 537 (1896).

<sup>54</sup> 347 U.S. 483 (1954).

Court.<sup>55</sup> Civil rights litigation in the health care area is designed, instead, to enforce existing law and, thereby, to inform and contribute to the movement for national health reform, not only this year but in the future, as new financing and delivery systems develop.<sup>56</sup> The wall of separation between health care for rich and poor, privately insured and uninsured, and white and black, has been a bulwark against a tide of true reform, as the poor and people of color lack political clout and the multi-tiered system has insulated many middle-class whites from sharing experiences of deprivation and denial.<sup>57</sup>

Litigation is only one of a number of approaches that must be taken to close the gap. The attack must be coordinated and multi-faceted, and it must include not only lawsuits, but legislative work, public education and outreach efforts, community action, and greater emphasis on the direct provision of care by health professionals in low-income communities. Although the recent judicial climate does not preclude the development and implementation of an effective litigation strategy, litigators must be cognizant of the increased importance of placing lawsuits in the context of multipronged advocacy. Litigation must not displace community involvement but, instead, be a means of community organizing and empowerment.

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<sup>55</sup> *But see* Peter B. Edelman, *The Next Century of Our Constitution: Rethinking Our Duty to the Poor*, 39 HASTINGS L.J. 1 (1987) (arguing for advocacy of judicial recognition of the rights of the poor, despite the currently unreceptive judicial climate).

<sup>56</sup> Litigation can help to hasten necessary reforms even in the absence of a national legislative overhaul of the financing and delivery of medical services. Whether or not any of the current health care reform bills become law, specific legislative and administrative actions must be taken to ensure access to care for people with low incomes and, particularly, for low-income people of color. For example, additional guidelines and regulations should be established to clarify areas of ambiguity in existing laws, such as which agency has jurisdiction and responsibility for reviewing major hospital construction projects for compliance with civil rights laws. HHS regulations, for example, should explicitly delegate responsibility for compliance reviews of hospital construction projects that receive federal mortgage guarantees.

<sup>57</sup> *See* Pear, *supra* note 25, at A1 (reporting on difficulties faced by Medicaid recipients, in contrast to Medicare recipients, that result from the lack of a broadly based body of political support for the Medicaid program).

### III. THE RELATIONSHIP BETWEEN BURDENS OF PROOF AND THE EXPERIENCE OF DENIAL

This Part focuses on a key problem with which advocates wrestle today, a problem that litigators challenging racial discrimination under a new regime will face as well. Specifically, advocates must find ways to span the gulf between the realities of denial experienced by the poor and recognition of such harm, in law and fact, by courts.<sup>58</sup> Since prior judicial findings against plaintiffs who previously challenged barriers of access quite obviously neither prevent nor nullify the very real experiences of exclusion sustained by our clients, it is the advocate's challenge to relate these experiences in a way that will be more meaningful in the realm of the law.

At first blush, civil rights and other laws that protect against racial discrimination and against the infringement of rights of access would seem to prohibit the erection of structural barriers to access. Legal standards under regulations promulgated pursuant to Title VI of the Civil Rights Act of 1964, for example, explicitly prohibit denials of access and actions with discriminatory effects,<sup>59</sup> as do the community service

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<sup>58</sup> The gulf between what is experienced and what is acknowledged as proof is much discussed in the context of the law of affirmative action. For example, Derrick Bell cites the *Bakke* decision, *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265 (1978), for its rigid application of rules in seemingly neutral ways that ignore real facts. In *Bakke*, "[t]he Court introduced . . . an artificial and inappropriate parity in its reasoning—that is, that blacks and whites applying to medical school have always been treated equally in a state that has never practiced racial discrimination—and thus chose to ignore historical patterns, contemporary statistics, and flexible reasoning." BELL, *supra* note 27, at 102. Similarly, Patricia Williams describes the judicial decision-making in *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469 (1989), as a "process by which the court consistently diminished the importance of real facts and figures." PATRICIA K. WILLIAMS, *THE ALCHEMY OF RACE AND RIGHTS: DIARY OF A LAW PROFESSOR* 106 (1991).

<sup>59</sup> Title VI states, in part,

No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

42 U.S.C. § 2000d (1982). 45 C.F.R. § 80.3(b)(2) (1992) provides: "A recipient . . . may not . . . utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color or national origin." (emphasis added). HHS regulations further state:

(b)(1) A recipient under any program to which this part applies may not, directly or through contractual or other arrangements, on ground of race,

regulations promulgated pursuant to the Hill-Burton Act.<sup>60</sup> Similarly, recent Supreme Court opinions have focused on the impact of laws regulating abortion services in determining whether these laws violate the judicially recognized right to privacy under the due process clauses of the Constitution's Fifth and Fourteenth Amendments. Specifically, the opinions examine whether statutory provisions produce an "undue burden" on the ability of women to obtain abortions.<sup>61</sup>

Yet time and time again, courts have looked askance at plaintiffs' challenges to denials of access and, specifically, at evidence of how defendants' methods of structuring the provision of health care burdens the poor. The problem has arisen in a number of contexts. This discussion will consider two:

color, or national origin:

(i) Deny an individual any service, financial aid, or other benefit provided under the program. . . .

(b)(3) In determining the site or location of a facilities [sic], an applicant or recipient may not make selections with *the effect* of excluding individuals from, denying the benefits of, or subjecting them to discrimination under any programs to which this regulation applies, on the ground of race, color, or national origin; or with the purpose *or effect* of defeating or substantially impairing the accomplishment of the objectives of the Act or this regulation.

45 C.F.R. § 80.3 (1992) (emphases added).

<sup>60</sup> The community service regulations state, in part:

[A] facility shall make the services provided in the facility . . . available to all persons residing . . . in the facility's service area without discrimination on the ground of race, color, national origin, creed, or any other ground unrelated to an individual's need for the service or the availability of the needed service in the facility.

42 C.F.R. § 124.603(a)(1) (1993). This provision not only prohibits discrimination on the basis of race, color, or national origin, but also requires that facilities be generally available to residents of the facility's service area. *See Wyoming Hosp. Ass'n v. Harris*, 727 F.2d 936, 940 (10th Cir. 1984); *see also* Kenneth R. Wing, *The Community Service Obligation of Hill-Burton Health Facilities*, 23 B.C. L. REV. 577, 600-10 (1982). The regulations further require that facilities "take any necessary steps to insure that admission to and services of the facility are available to beneficiaries of [Medicaid and Medicare] without discrimination or preference because they are beneficiaries of those programs," 42 C.F.R. § 124.603(c)(2) (1993), and, perhaps most importantly, that "[a] facility is out of compliance . . . if it uses an admission policy that *has the effect of excluding persons* on a ground other than those permitted." 42 C.F.R. § 124.603(d) (emphasis added). Subsection (d) lists illustrative examples of exclusionary admissions practices.

<sup>61</sup> *See, e.g., Planned Parenthood of Southeastern Pa. v. Casey*, 112 S. Ct. 2791, 2819 (1992) (O'Connor, Kennedy and Souter, JJ., announcing the judgment of the Court).

hospital relocation cases brought pursuant to Title VI, and challenges to restrictions on the provision of abortion services, restrictions that have particular effects on the ability of poor women to access reproductive health services.<sup>62</sup> In both contexts, the challenged actions place barriers of access in the paths of the poor and burden their ability to obtain care. In both, facial readings of the applicable legal standards suggest that plaintiffs would be able to meet their burdens of proof. But in each, the experience of the poor has been devalued. Courts dismiss hardships faced by poor patients as (a) mere inconveniences or slight alterations in the options available, to be overcome by increased effort to obtain services on the part of poor individuals;<sup>63</sup> or (b) issues of money, outside the purview of the courts.<sup>64</sup> In each case, court assessments

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<sup>62</sup> See *id.*; *Rust v. Sullivan*, 500 U.S. 173 (1991).

<sup>63</sup> Compare *Bryan v. Koch*, 492 F. Supp. 212, 237 (S.D.N.Y.) (finding that the closure of Sydenham Hospital would "affect a comparatively small number of persons," that "adequate alternative treatment appears available for most, if not all, of these persons," and that "any inconvenience due to travel changes in this case do not rise to the level of harm necessary to enlist the equitable powers of [the] court."), *aff'd*, 627 F.2d 612 (2d Cir. 1980) with *Bryan v. Koch*, 627 F.2d 612, 626-28 (1980) (Kearse, J., dissenting) (discussing the potential impact of the closure and concluding that defendants had "ignored major practical problems which Sydenham's patients would encounter after a closure," including those resulting from the patients' medical indigence and the failure of other, nearby hospitals to accept uninsured patients). See also *United States v. Bexar County Hosp. Dist.*, 484 F. Supp. 855 (W.D. Tex. 1980). After noting that "there will probably be some inconvenience encountered" in arranging for transportation to the new site of obstetric and nursery services, the court in *Bexar* minimized the issue:

When it is made clear to them that the best medical care possible in a full service hospital, equipped to handle known and unanticipated complications, will be available to them and their newborn babies, . . . [the plaintiffs] will have both the ability and good judgment to act in their own best interest as well as that of their babies.

*Id.* at 859-60.

<sup>64</sup> See, e.g., *Rust*, 500 U.S. at 203 (while acknowledging, "[i]t would undoubtedly be easier for a woman seeking an abortion if she could receive information about abortion from a Title X project," the Court rejected the claim that prohibiting Title X clinics from providing such information was constitutionally infirm: "The financial constraints that restrict an indigent woman's ability to enjoy the full range of constitutionally protected freedom of choice are the product not of governmental restrictions on access to abortion, but rather of her indigency.") (quoting *Harris v. McRae*, 448 U.S. 297, 316 (1980)); see also *Casey*, 112 S. Ct. at 2819 (although regulations with an undue burden reach into the heart of the liberty protected by the Due Process Clause, "[t]he fact that a law which serves a valid purpose . . . has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it"). Note, howev-

delegitimize or trivialize denials of access faced by the poor.<sup>65</sup>

In practice, judicial devaluation of the significance of barriers of access can take a number of forms. First, courts "up the ante", transforming a standard that requires proof of adverse impact, or evidence that defendant's decision, action, policy or practice "burdens" an activity, into a more stringent requirement, one that compels plaintiffs to demonstrate that they were foreclosed or barred from access.<sup>66</sup> While under the more stringent test plaintiffs remain able to challenge some flagrant forms of exclusion, the use of an "effective foreclosure" or "bar" test rarely, if ever, allows plaintiffs to be successful on claims against structural forms of discrimination. Second, courts look dismissively at factual evidence of harm presented by plaintiffs, thereby ensuring that plaintiffs' proof will be deemed insufficient to meet the requirement that plaintiffs show the adversity or burden caused by defendant's action.<sup>67</sup>

#### A. *Challenges to Discriminatory Hospital Relocations:*

##### *Mussington v. St. Luke's Roosevelt Hospital Center*

*Mussington v. St. Luke's Roosevelt Hospital Center*<sup>68</sup> was filed in the Southern District of New York on behalf of community residents to challenge the movement of obstetric, neonatal intensive care, pediatric and other inpatient services out of the Harlem area.<sup>69</sup> In 1986, New York's St. Luke's Roosevelt Hos-

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er, that the opinion of Justices O'Connor, Kennedy and Souter leaves open the possibility of judicial recognition of the burdens resulting from increases in expense. While the opinion recognizes no such showing on the record in *Casey*, the opinion explicitly states that "at some point increased cost could become a substantial obstacle." *Id.* at 2833.

<sup>65</sup> See BELL, *supra* note 27, at 111 ("Black people (while they may be able to get into court) are denied such standing legitimacy in the world generally when they discuss their negative experiences with racism."); see also WILLIAMS, *supra*, note 58, at 55-58 (discussion and illustration of invisibility and devaluation). Bell writes, "Isn't this the point of *Invisible Man*, . . . where Ralph Ellison depicts blacks as a category of human beings whose suffering is so thoroughly ignored that they, and it, might as well not exist?" BELL, *supra* note 27, at 155.

<sup>66</sup> See, e.g., *Jackson v. Conway*, 476 F. Supp. 896, 904 (E.D. Mo. 1979) (holding that consolidation of hospital services would not effectively foreclose plaintiffs from using those services).

<sup>67</sup> See, e.g., *Casey*, 112 S. Ct. at 2820.

<sup>68</sup> *Mussington v. St. Luke's Roosevelt Hosp. Ctr.*, No. CIV.92-89618 (S.D.N.Y. filed Dec. 11, 1992) (complaint).

<sup>69</sup> *Id.* In June 1993, *Mussington* was dismissed on procedural grounds. 824 F.

pital Center had announced plans to transfer its maternal and child care beds from a site near the medically underserved communities of Central and West Harlem to the hospital's downtown location, which serves a community that is less populated, in larger proportion white, generally healthier and of higher average income.<sup>70</sup> The complaint alleged violations of Title VI and the Hill-Burton Act. In many ways, this case was a civil rights litigator's dream—lawyers represented community residents and groups that struggled on their own for five years before attorneys appeared on the scene. Community members fought in the political arena, held candlelight vigils, and otherwise demonstrated their strong commitment to retaining services that are accessible to Harlem residents. The client group had very clear ideas about how they were being harmed. They felt that, given the high incidence of illness in their communities and the shortage of providers,<sup>71</sup> they could not afford the loss of a single hospital bed, much less the loss of the 300 or so—including all beds in the pediatric, obstetric and neonatal intensive care units—that were slated for removal from the Harlem area at the time.

Moreover, the mandates of statutory law were on

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Supp. 427 (S.D.N.Y. 1993), *aff'd*, 18 F.3d 1033 (2d Cir. 1994). An investigation of St. Luke's relocation of services by HHS's Office for Civil Rights continues, however. Community groups initiated the administrative procedure in 1991 by filing a complaint that alleged civil rights violations.

<sup>70</sup> See WEST SIDE/WEST HARLEM COMMUNITY HEALTH PLANNING COALITION, REPORT AND RECOMMENDATIONS ON MATERNAL AND CHILD HEALTH NEEDS IN WEST HARLEM, MORNINGSIDE HEIGHTS AND MANHATTAN VALLEY 15-34 (Apr. 1989) (comparing indicators of socioeconomic and health status in the northern portion of the hospital's service area, which includes Central and West Harlem, and the downtown or southern portion).

<sup>71</sup> *Id.* at 35 (finding that "[w]hile pockets of need exist in the southern portion of the [St. Luke's Roosevelt Hospital Center] service area, the greatest need exists in the northern portion"). Harlem and other neighborhoods near the hospital's uptown site, for example, experience high infant mortality rates, high rates of little or no prenatal care, high percentages of low birthweight babies, high teenage pregnancy rates and high rates of deliveries by mothers who are substance abusers or who suffer from chronic or acute illness. These factors create a greater need for inpatient maternal and child care services that are accessible and that are equipped to respond to high-risk pregnancies. *Id.* at 11; see also Christel Brelochs et al., *Building Primary Health Care in New York City Low-Income Communities, 1990* (Community Service Society 1990) (reporting on the low number of physicians available to nine low-income communities in New York City); Colin McCord & Harold P. Freeman, *Excess Mortality in Harlem*, 322 NEW ENG. J. MED. 173 (1990).

plaintiffs' side, except that plaintiffs faced unfavorable precedent set by a few past hospital relocation cases. Although the precedent could easily be distinguished, its presence created an imposing hurdle for this kind of litigation.<sup>72</sup> Specifically, courts in three cases, *United States v. Bexar County Hospital District*,<sup>73</sup> *NAACP v. Wilmington Medical Center, Inc.*,<sup>74</sup> and *Bryan v. Koch*,<sup>75</sup> refused to enjoin the removal of services by health care providers from African American and Latino to white communities, despite strong evidence of discrimination and, significantly for this discussion, evidence of the need for those services in the communities of color, as well as of the harm that would be caused by their departure.<sup>76</sup> Despite im-

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<sup>72</sup> Not all hospital relocation and closure cases have ended in determinations against plaintiffs. See, e.g., *Heath v. Charlotte-Mecklenburg Hosp. Auth.*, 681 F.2d 814 (4th Cir. 1982); *Terry v. Methodist Hosp. of Gary*, Nos. H-76-373 and H-77-154 (N.D. Ind.) (consent decree entered into on June 8, 1979).

Interestingly, Sydenham Hospital, the facility at issue in one of the cases in which plaintiffs were denied relief, *Bryan v. Koch*, 492 F. Supp. 212 (S.D.N.Y.), *aff'd*, 627 F.2d 612 (2d Cir. 1980), had been located only blocks away from St. Luke's, the site that defendants in *Mussington* now plan to downsize. Indeed, in the past two decades the Harlem area lost a number of facilities to policies that called for bed reductions Manhattan-wide but allowed these reductions to occur primarily in those poverty-stricken communities with the greatest need for health care services and the least mobility. See Sara McLafferty, *The Geographical Restructuring of Urban Hospitals: Spatial Dimensions of Corporate Strategy*, 23 SOC. SCI. MED. 1079 (1986) (study of hospital closures in New York).

Not only was Sydenham located near St. Luke's, but it also served a similar, albeit smaller, patient population. Significantly, during the years since *Bryan*, medical geographer Sara McLafferty analyzed the accuracy with which planners had predicted changes in utilization that would result from the closure of Sydenham. Sara McLafferty, *Predicting the Effect of Hospital Closure on Hospital Utilization Patterns*, 27 SOC. SCI. MED. 255 (1988) [hereinafter *Hospital Closure*]. Contrary to claims made by St. Luke's Roosevelt Hospital Center that patients would easily travel from Northern Manhattan to their Roosevelt Division downtown, McLafferty found that Sydenham patients moved to familiar nearby facilities rather than distributing as had been forecasted. Specifically, fewer Sydenham patients than expected had moved to hospitals located to the east or south. In fact, fewer than expected had moved to Roosevelt. *Id.*

<sup>73</sup> 484 F. Supp. 855 (W.D. Tex. 1980).

<sup>74</sup> 491 F. Supp. 290 (D. Del. 1980), *aff'd*, 657 F.2d 1322 (3d Cir. 1981).

<sup>75</sup> 492 F. Supp. 212 (S.D.N.Y.), *aff'd*, 627 F.2d 612 (2d Cir. 1980).

<sup>76</sup> The posture and facts of each of these cases were unique. For example, in *NAACP v. Wilmington Medical Center, Inc.*, the Office for Civil Rights ("OCR") at the U.S. Department of Health, Education & Welfare had already found the Medical Center's plan out of compliance with Title VI and had entered into a compliance agreement with defendants. See *NAACP v. Wilmington Med. Ctr., Inc.*, 453 F. Supp. 280, 291-92 (D. Del. 1978) (Second Supplemental Report to Court Concerning Investigation of Plan Omega with Respect to Alleged Title VI and Section

pressive demonstrations of fact, the issue of harm was a sticking point in these cases<sup>77</sup> and as preparation for *Mussington* began, plaintiffs' lawyers realized that they needed to reformulate how to prove that moving hospital services away from those in greatest need—and away, not incidentally, from those with the least mobility—would have adverse effects.<sup>78</sup>

The fact that the loss of beds would adversely effect Harlem residents in need of inpatient care was obvious to the *Mussington* plaintiffs and other coalition members. For example, community residents stressed how important time can be to treatment.<sup>79</sup> For a child with severe asthma or a seizure that causes respiratory failure, a few minutes might affect his or her chances for survival. Women in labor most often do not have the time or ability to take a bus or ride a subway to the hospital; and, for high-risk patients in labor, travel time by car influences choice of facility and, in turn, has an impact on the

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504 Violations). Plaintiffs' case attacked the Medical Center's plan as already modified by the agreement between OCR and defendants. *Wilmington Med. Ctr.*, 657 F.2d. at 1325-26. In *Bryan*, plaintiffs challenged the City of New York's plan to close Sydenham Hospital, a small facility in Harlem. Both Judge Sofaer and the Second Circuit panel took into consideration the factual circumstances surrounding the hospital closure, the most important of which were the city's horrific financial condition at the time and the fact that Sydenham was an obsolete facility. In their decisions, both courts relied on the finding that the city based its decision to close Sydenham upon four sets of criteria that were reasonably related to the efficient operation of the city's hospital system. *Bryan*, 627 F.2d at 618.

In addition, all three of these cases preceded *Guardians Ass'n v. Civil Serv. Comm'n of New York*, 463 U.S. 582 (1983), in which the Supreme Court made clear that Title VI can reach unintentional forms of discrimination that have disparate effects, as well as deliberate discrimination. *Id.* at 593 (opinion of White, J., joined in his conclusion by Stevens, Brennan, Blackman and Marshall, JJ.); see also *Alexander v. Choate*, 469 U.S. 287, 293-94 (1985). Plaintiffs need not provide evidence that health care defendants intentionally discriminated in actions to enjoin practices with disproportionate impact on members of one or more minority group, *Guardians*, 463 U.S. at 607. Proof of intentional discrimination, however, may be necessary to obtain monetary damages. See *Consolidated Rail Corp. v. Darrone*, 465 U.S. 624 (1984); but see *Franklin v. Gwinnett County Pub. Schs.*, 112 S. Ct. 1028 (1992) (damages remedy available for an action brought to enforce parallel statute, Title IX).

<sup>77</sup> See, e.g., *Wilmington Med. Ctr.*, 657 F.2d at 1332 ("all of us are not completely persuaded that plaintiffs met their burden [of proving disparate impact] here."); *Bexar*, 484 F. Supp. at 859-60.

<sup>78</sup> The task of proving the other prong of the prima facie case under Title VI, disproportionality—i.e. that adverse effects will be felt disproportionately on the basis of race, color or national origin—is analytically distinct.

<sup>79</sup> Meeting in Manhattan Residence, *supra* note 28.

likelihood of delivering healthy babies. Area residents spoke about how location affects accessibility—greater distances not only increase travel time, but also the cost of transportation.<sup>80</sup> Currently, for example, at least one local tenants' association keeps a few dollars on hand in case of emergency. If a resident needs to take a cab to the nearest hospital, people lend or donate the necessary four to six dollars. The supply of money is based on contributions from low-income tenants and is limited.

Moreover, residents had particular concerns about the loss of pediatric beds.<sup>81</sup> When children are in the hospital, their parents need to make frequent visits. How, the residents asked, can people visit their children, keep their jobs and watch their other children if travel time and expenses are increased?<sup>82</sup> Parents already borrow money to cover the costs of transportation and babysitting. The farther the hospital, the more resistant parents become to bringing their children to the hospital, even though there are few, if any, alternative sources of health care.

Community members became impassioned when discussing the extent to which Harlem is so grossly underserved and, also, how the area had already lost approximately ten hospitals. They felt strongly that St. Luke's Roosevelt Hospital Center was moving services in order both to reduce the number of African American and Latino patients and to try to attract more middle-class whites.<sup>83</sup>

In fact, studies in medical geography conducted in the past two decades confirm what the clients knew: the loss of beds would limit access and change patterns of hospital use, with harmful effect.<sup>84</sup> Research has shown that proximity, familiar-

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<sup>80</sup> Meeting in Manhattan Residence, *supra* note 28.

<sup>81</sup> Meeting in Manhattan Residence, *supra* note 28.

<sup>82</sup> Meeting in Manhattan Residence, *supra* note 28.

<sup>83</sup> Meeting in Manhattan Residence, *supra* note 28.

<sup>84</sup> Indeed, the merits of regionalizing highly technological and expensive health services should not obscure either the significance of decisions as to where regional facilities should be located or the desirability of making such facilities accessible to all. See Sara McLafferty & Daniel Broe, *Patient Outcomes and Regional Planning of Coronary Care Services: A Location-Allocation Approach*, 30 SOC. SCI. MED. 297 (1990). Moreover, without taking exception to the desirability of the recent emphasis on preventive care, see, e.g., James F. Fries et al., *Reducing Health Care Costs by Reducing the Need and Demand for Medical Services*, 329 NEW ENG. J. MED.

ity, and socioeconomic and cultural factors are determinants of access, as evidenced by hospital utilization.<sup>85</sup>

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321 (1993), it must be conceded that the accessibility of inpatient care makes a difference. For an entry into the extensive literature on the relationship between the availability of tertiary care facilities and birth outcomes, see, e.g., Cynthia J. Berg et al., *Neonatal Mortality in Normal Birth Weight Babies: Does the Level of Hospital Care Make a Difference?*, 161 AM. J. OBSTETRICS & GYNECOLOGY 86 (1989); Kwang-Sun Lee et al., *Neonatal Mortality: An Analysis of the Recent Improvement in the United States*, 70 AM. J. PUB. HEALTH 15, 19 (1980) (noting the impact of neonatal intensive care in lowering birth-weight-specific mortality); Lula O. Lubchenco et al., *Outcome of Very-Low-Birth Weight Infants: Does Antepartum Versus Neonatal Referral Have a Better Impact on Mortality, Morbidity, or Long-Term Outcome?*, 160 AM. J. OBSTETRICS & GYNECOLOGY 539 (1989); Nigel Paneth et al., *Newborn Intensive Care and Neonatal Mortality in Low-Birth Weight Infants: A Population Study*, 307 NEW ENG. J. MED. 149 (1982).

Officials at other health care facilities serving Northern Manhattan also warned that the loss of beds near Harlem would limit access to St. Luke's Roosevelt Hospital Center and shift patients to the public hospitals, with adverse consequences. See, e.g., Letter from Edward B. Heaton, M.D., Medical Director, Harlem Hospital, and Stanford A. Roman, Jr., M.D., Senior Vice President, Medical & Professional Affairs, New York City Health & Hospitals Corporation, to Robert Gumbs, Executive Director, New York City Health Systems Agency (Mar. 29, 1990) (stating that "there is a severe problem of overcrowding in the [neonatal intensive care] units" in Northern Manhattan, that the location of obstetric and neonatal beds is not irrelevant to the issue of access, that the movement of beds downtown would shift patients—and, particularly, higher risk patients—to Harlem Hospital, and that Harlem Hospital would be unable to meet the increased demand) (on file with author); Letter from Margaret Grossi, M.D., MPH, Acting Commissioner of Health, New York City Department of Health, to David Axelrod, M.D., New York State Commissioner of Health (Mar. 29, 1990) (expressing concern about the movement of maternal and neonatal health services and its effect on accessibility and delivery of services) (on file with author).

<sup>85</sup> See, e.g., Rashid L. Bashshur et al., *Some Econological Differentials in the Use of Medical Services*, 6 HEALTH SERV. RES. 61, 75 (1971); Wilbert M. Gesler & Melinda S. Meade, *Locational and Population Factors in Health Care-Seeking Behavior in Savannah, Georgia*, 23 HEALTH SERV. RES. 443, 444, 456-59 (1988) (distance from home to regular source of care was a relatively more important factor for inner-city residents than for suburban residents; proximity to daily activity areas is a significant determinant for the poor, whereas more mobile suburbanites, who are accustomed to traveling relatively long distances for work or shopping, can incorporate a stop for health services into their routine trips); Marjorie A. McGuirk & Frank W. Porell, *Spatial Patterns of Hospital Utilization: The Impact of Distance and Time*, 21 INQUIRY 84 (1984); McLafferty, *Hospital Closure*, *supra* note 72, at 255 (study of utilization patterns after closure of Sydenham Hospital in New York); Klaus J. Roghman & Thomas R. Zastowny, *Proximity as a Factor in the Selection of Health Care Providers*, 130 SOC. SCI. MED. 61, 68 (1979) (distance and prior experience are predictors of utilization); Gary W. Shannon et al., *Time and Distance: The Journey for Medical Care*, 3 INT'L J. HEALTH SERV. 237, 243 (1983) (the inner-city poor expend more time in the journey for health care, though going shorter distances, and are, thus, at a disadvantage when seeking care); Gary W. Shannon et al., *The Search for Medical Care: An Exploration of*

The primary obstacle we, as lawyers, face in hospital relocation and closure cases is no longer the adoption of appropriate statutory language, the promulgation of regulations to prohibit actions with disparate effects, nor judicial recognition of such standards. Applicable anti-discrimination provisions now clearly require demonstrations of disparate effects and not evidence of discriminatory intent.<sup>86</sup> Today, however, we must confront the mismatch between the experiences of our clients, who must contend with barriers of access, and the unwillingness of courts to acknowledge these experiences and to accord them weight.<sup>87</sup> When a facility moves away from an African American or Latino community, particularly one with a high demand for medical services, thereby curtailing access, advocates must find ways of proving the element of harm to the courts, and, thus, of demonstrating the discriminatory nature of the action.

B. *Challenges to Restrictions on the Provision of Abortion Services: Planned Parenthood of Southeastern Pennsylvania v. Casey*

The challenge is similar for advocates representing low-income women of color in suits against restrictions on access to abortion services. In *Planned Parenthood of Southeastern Pennsylvania v. Casey*,<sup>88</sup> the Supreme Court affirmed the con-

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*Urban Black Behavior*, 8 INT'L J. HEALTH SERV. 519, 530 (1978) (the spatial distribution of medical care is an important determinant of utilization; and few if any members of lower- or middle-class, African American communities studied access suburban medical care).

<sup>86</sup> For pre-*Guardians* cases and analyses discussing issues that have since been resolved, at least in part, see, e.g., *Bryan v. Koch* 627 F.2d 612, 616 (2d Cir. 1980) (discussing arguments for and against application of the intent standard to claims pursuant to Title VI); see also Marilyn G. Rose, *Can Hospital Relocations and Closures Be Stopped Through the Legal System?* 18 HEALTH SERVS. RES. 551, 557-58 (stating, "dicta in two more recent Supreme Court cases cast a shadow over the discriminatory impact doctrine under Title VI"); Valerie A. Seiling, Note, *The Prima Facie Case and Remedies in Title VI Hospital Relocation Cases*, 65 CORNELL L. REV. 689 (1980); Richard J. Zall, Note, *Maintaining Health Care in the Inner City: Title VI and Hospital Relocations*, 55 N.Y.U. L. REV. 271 (1980).

<sup>87</sup> Judicial recognition of the harms caused by hospital relocations, for example, is necessary both for establishing plaintiffs' prima facie case of discrimination under Title VI and for prevailing on a motion for preliminary injunction in such cases.

<sup>88</sup> 112 S. Ct. 2791 (1992).

stitutionality of a provision of the Pennsylvania Abortion Control Act that imposed a 24-hour waiting period before the performance of an abortion.<sup>89</sup> The joint opinion by Justices O'Connor, Kennedy and Souter states clearly, "A finding of undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a non-viable fetus."<sup>90</sup> Despite evidence before the Court that the waiting period and other restrictions would actively interfere with the ability of poor women to obtain abortions,<sup>91</sup> the Court, with little discussion and seemingly little consideration, concluded that these provisions were not substantial obstacles to obtaining an abortion.<sup>92</sup>

It is clear that the 24-hour waiting period, for example, will significantly increase the costs and accessibility of abor-

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<sup>89</sup> The Court upheld the informed consent provision, 18 PA. CONS. STAT. ANN. § 3205(a) (Supp. 1994), and the mandated parental consent provision, 18 PA. CONS. STAT. ANN. § 3206 (Supp. 1994). However, the Court struck the Act's requirement of spousal notification, 18 PA. CONS. STAT. ANN. § 3209 (Supp. 1994). *Casey*, 112 S. Ct. 2791, 2831.

<sup>90</sup> *Casey*, 112 S. Ct. at 2820.

<sup>91</sup> See Amici Curiae Brief of the NAACP Legal Defense and Educational Fund, Inc., and Other Organizations, in Support of Planned Parenthood of Southeastern Pennsylvania, 505 U.S. 112 S. Ct. 2791 (Nos. 91-744, 91-902) [hereinafter LDF Brief]; Brief of Amicus Curiae American Psychological Association ("APA") in Support of Petitioners, 505 U.S. 112 S. Ct. 2791 (Nos. 91-744, 91-902) [hereinafter APA Brief].

Admittedly, evidence before the Court that the Act's provisions constituted an undue burden was not fully developed, since plaintiffs had prepared their case below to trigger the strict scrutiny standard of review, the prevailing standard before the Court delivered the *Casey* decision. On remand, plaintiffs moved to re-open the record to allow the introduction of new evidence to satisfy the undue burden standard. The district court granted plaintiffs' motion, 822 F. Supp. 227 (S.D. Pa. 1993), but was reversed on review by the Third Circuit. 14 F.3d 848 (3d Cir. 1994), *application for stay denied*, 114 S. Ct. 909 (1994).

<sup>92</sup> *Casey*, 112 S. Ct. at 2824, 2826. The finality of the Court's conclusions was subject to doubt until recently. Upon remand, the district court granted plaintiffs' motion to re-open the record in order to allow additional evidence that the challenged provisions constitute an undue burden, finding that although the Supreme Court had ruled on the constitutionality of the Act's provisions on the record before it, the Court's decision did not preclude an evaluation of constitutionality based on supplementary evidence. 822 F. Supp. 227, 233 (E.D. Pa. 1993). The Third Circuit reversed, specifically finding that "[t]he language of the Supreme Court's opinion makes clear that the Court applied the new standard and decided the merits." 14 F.3d 848, 857 (3d Cir. 1994); *application for stay denied*, 114 S. Ct. 909 (1994) (Souter, J.).

tions for poor women because of the limited availability of abortion services.<sup>93</sup> As one brief for amici curiae suggested:

For poor women, it is already more difficult to find the necessary financial resources, medical information, child care and time away from work. The additional delay imposed by the 24-hour waiting period—exacerbated by the likelihood of scheduling difficulties at overcrowded facilities at which poor women receive care, as well as barriers of distance and mobility—will actively interfere with the ability of poor women and women of color to obtain abortions.<sup>94</sup>

Again, the problem is less the standard, if one takes it at face value, and more the mismatch between the actual hardships faced by the poor as a result of restrictions on the provision of services and what is accepted as proof by courts, which have a tendency to dismiss the particular experiences of low-income people of color.<sup>95</sup>

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<sup>93</sup> See M. Lupfer & B. Goldfarb Silber, *How Patients View Mandatory Waiting Periods for Abortion*, 13 FAM. PLAN. PERSP. 75 (1981) (finding that a waiting period of two days increased the costs of abortion for low-income women by approximately 48% and for higher income women by 14%); see also National Abortion Federation & American College of Obstetricians & Gynecologists, *Who Will Provide Abortions?: Ensuring the Availability of Qualified Practitioners* (Oct. 25-26, 1990) (recommendations from a National Symposium: Santa Barbara, Cal.) (discussing the shortage of physicians willing to provide abortions); Amici Curiae Brief of the American Public Health Association et al., in Support of Appellees at 22-23, *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989) (stating that as many as 21% of metropolitan areas and 91% of nonmetropolitan areas lack abortion providers, that "once a provider is located, transportation may be difficult to arrange or afford," and that scheduling and communications may become problems, and concluding, "Thus, by imposing increased cost and delay upon a woman seeking abortion, the state forces her into a situation where her ability to obtain a safe abortion is dramatically reduced.") (citing Stanley K. Henshaw et al., *Abortion Services in the United States, 1984 and 1985*, 19 FAM. PLAN. PERSP. 63 (1987); Stanley K. Henshaw, *Reducing Teenage Childbearing*, 78 AM. J. PUB. HEALTH 619 (1988)).

<sup>94</sup> LDF Brief, *supra* note 91, at 20 (footnote omitted). In support of the position that the waiting period severely burdens a woman's right to choose, the APA stated that:

In many geographic areas of the country, women live long distances, even hundreds of miles, from the nearest abortion provider. Research has shown that the greater the distance from a provider, the less likely a woman is to gain access to the abortion service. The lack of local services can result in numerous difficulties for women seeking an abortion: travel expenses, overnight lodging, loss of pay, and jeopardized privacy because of absence from work and/or home for a significant period of time. . . . To add a 24-hour mandatory waiting period will impose an excessive burden on many women, and for some women may prevent them from receiving an abortion.

APA Brief, *supra* note 91, at 28-29 (footnote omitted).

<sup>95</sup> For a recent report on the difficulties faced by women seeking abortion ser-

## CONCLUSIONS

What conclusions can be drawn from these examples? First, we must acknowledge that courts are not applying impact-oriented standards in a neutral way. Perhaps such standards were not meant to pertain to the experiences of deprivation felt by poor people of color. Perhaps, simply put, judges administer or apply the standards in a biased manner, whether conscious or unconscious of the bias.<sup>96</sup> As advocates, we must, nevertheless, find ways of demonstrating the harm in fact and of highlighting, in Cornel West's words, "the legal system's internal contradictions and blatant hypocrisy, using the very ideals—fairness, protection, formal equality—it her-

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vices, see Tamar Lewin, *Hurdles Increase for Many Women Seeking Abortions*, N.Y. TIMES, Mar. 15, 1992, § 1, at 1.

<sup>96</sup> See generally BRUCE WRIGHT, *BLACK ROBES, WHITE JUSTICE* (1987) (describing how racism permeates the legal profession and the administration of justice). In analyzing the gulf between actual experience and the prevailing mode of judicial analysis of such facts, some legal scholars have suggested that the courts' failure to recognize the reality of hardship may be due to the distinct life experiences of judges and, also, to cultural, unconscious racism. See, e.g., Jerome McCristal Culp, *Toward a Black Legal Scholarship: Race and Original Understanding*, 1991 DUKE L.J. 39, 41-42, 58-62 (discussing the delusion of neutrality held by some whites in the judiciary and stating that "[m]ost legal scholars, judges, and law students do not know that they approach the question of law from a perspective that excludes black concerns"). Unconscious racism is discussed at length in Lawrence III, *supra* note 27, at 322, 329-44. Lawrence writes,

Americans share a common historical and cultural heritage in which racism has played and still plays a dominant role. Because of this shared experience, we also inevitably share many ideas, attitudes, and beliefs that attach significance to an individual's race and induce negative feelings and opinions about nonwhites. To the extent that this cultural belief system has influenced all of us, we are all racists.

*Id.* at 322 (footnote omitted); see also John O. Calmore, *Critical Race Theory, Archie Shepp, and Fire Music: Securing an Authentic Intellectual Life in a Multicultural World*, 65 S. CAL. L. REV. 2129, 2144 (1992) ("Although the world of black Americans since slavery has been an integral part of American society, the worlds of blacks and whites have been intensely separate. . . . It is, therefore, no surprise that blacks and whites so often see quite different realities at both the perceptual and experiential levels."); Richard Delgado, *The Ethereal Scholar: Does Critical Legal Studies Have What Minorities Want?*, 22 HARV. C.R.-C.L. L. REV. 302, 316-18 (1987) (discussing "Theories of Race and Racism"); A. Leon Higginbotham, Jr., *The Bicentennial of the Constitution: From a Racial Perspective* 11 (Nov. 12, 1987) (remarks at Association of the Bar of the City of New York asserting relevance of racial perspective and sense of identification for interpretation of the Constitution).

alds."<sup>97</sup> We must build on our evidentiary base and make our case with greater force.

To be more effective in demonstrating harm, we need to consider strengthening relationships with social scientists working in such fields as health planning and epidemiology.<sup>98</sup> For instance, although current medical geography literature is relevant to the hospital relocation issue, much could be done to demonstrate more conclusively the impact of moving services and, specifically, the effect of relocations and closures on utilization. First, medical geographers and health planners might be able to assist one another in developing a sound methodology for determining where inpatient beds and outpatient services are needed, one that takes into account both medical need, i.e., the incidence of illness in the population, and utilization patterns.<sup>99</sup> Experts could then apply the methodology and present their findings in court. Such testimony might provide: (a) a sound means of assessing the legitimacy of defendants' claims that medical need justified the relocation or closure of services; (b) a measure for determining whether defendants' action represented the least discriminatory alternative; and (c) an additional indicator of the impact of the movement or closure of services on the ability of a population to obtain needed medical care.

Second, advocates might consider using the results of sur-

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<sup>97</sup> West, *supra* note 50, at 1802.

<sup>98</sup> In the late 1980s, for example, a number of civil rights and poverty law organizations coalesced to initiate an effort to cooperate on the promotion of scholarship on questions of race and poverty and to form ongoing, if informal, relationships with researchers. By establishing the Poverty & Race Research Action Council ("PRRAC"), the NAACP Legal Defense & Educational Fund, Inc., the Center for Law and Social Policy, the American Civil Liberties Union, the Georgia Legal Services Program, the National Housing Law Project, and the Children's Defense Fund, among other groups, hoped to create a climate for better communications with researchers whose fields touch on issues of access, opportunity and equity in the provision of health care, housing, education and other key areas. PRRAC strives to generate productive interaction between advocates and researchers through dialogue; for example, it convenes periodic conferences and publishes a newsletter. PRRAC also funds specific research projects that are considered to be both solid methodologically and of interest to advocates.

<sup>99</sup> In a number of states, utilization data is available that can provide researchers with information on the composition of patients in a given facility by race, gender, age and insurance type, as well as by methods of admission, zip codes of residence and categories of services rendered. New York State's "SPARCS" data is but one example.

veys and in-depth interviews to supplement current information on hospital utilization. While statistical analyses of the impact of relocating or closing services on patterns of utilization can demonstrate where patients are treated after the movement or closure of beds, the numbers fail to explain adequately the causes of the impact.<sup>100</sup> The statistical studies, and the expert witnesses who testify to their results, leave courts wondering *why* patients so often do not go for treatment to the suburbs or to the gentrified areas of town that now house new or modernized facilities. Of course, plaintiffs and area residents do testify about the impact of a relocation or closure on their ability to obtain timely and appropriate care. This testimony can be crucial, but may also be dismissed by courts as anecdotal or amounting only to demonstration of inconvenience for a few select members of the population.<sup>101</sup> Expert testimony on this issue may lend support for plaintiffs' statements, diminishing the possibility that courts will discount them as idiosyncratic or unrepresentative, and can help to refute defendants' claims that patients will, in fact, follow the beds. Surveys and in-depth interviews of community members might, thus, help to fill the gap.<sup>102</sup> One such study of women of childbearing age in low socioeconomic neighborhoods in the vicinity of the uptown site of St. Luke's Roosevelt Hospital Center, for example, found that no more than 34% of those surveyed—no more than 34% of a sample that was sociodemographically representative of women who would otherwise use the uptown site, the location situated near Harlem—could be expected to seek obstetric care downtown once

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<sup>100</sup> See McLafferty, *supra* note 72 (statistical study of changes in utilization that distinguishes between predictive model and analysis of causative factors).

<sup>101</sup> See *United States v. Bexar County*, 484 F. Supp. 855, 859-60 (W.D. Tex. 1980) (discounting plaintiffs' claims of inaccessibility and acknowledging the testimony of private plaintiffs not for its substance but, instead, to rationalize the court's judgment: the opinion stated "that after having closely observed the demeanor of the private plaintiffs, and their ability to respond to questions while testifying," the court believed that they had "the intelligence and judgment" to travel to the new facilities to deliver their newborns).

<sup>102</sup> Both surveys and in-depth interview techniques are means to explore relationships and to develop causative models. See ROBERT E. LANE, *POLITICAL IDEOLOGY* (1962) (groundbreaking work that used intensive, individual interviews to explore political beliefs); see also JENNIFER L. HOCHSCHILD, *THE NEW AMERICAN DILEMMA* (1984) (more recent study of attitudes and behavior around issues of integration and education based on analysis of surveys and individual interviews).

services were moved.<sup>103</sup> This study was also able to identify factors, such as distance to care and past experience, that appeared to influence the population's health care seeking behavior.<sup>104</sup>

And while there are already tremendous efforts to gather materials on the use of family planning and abortion services and the impact of regulations on the provision of abortions, generally,<sup>105</sup> advocates must ensure that research focuses on the particular impact on low-income women of color. Where do women in poor counties and in rural and urban areas go for services? How do low-income women of color travel to providers? How do parental consent provisions affect the choices of adolescents from low-income families?<sup>106</sup> How do such provisions affect their rates of utilization? How do mandatory waiting periods affect the choices of low-income women of color?<sup>107</sup> And what has been the impact of past state restrictions on utilization by low-income women of color?<sup>108</sup> In order to demonstrate the undue burden that restrictions place on our clients, we must present relevant anecdotal evidence in court

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<sup>103</sup> Luis Gomez, *Hospital Relocation and Health Care-Seeking Behavior Patterns of Inner-City Poor* 33, 42 (1992) (unpublished thesis, Mount Sinai School of Medicine, New York) (reporting on a series of structured interviews with a sample of women of childbearing age that investigated factors appearing to influence respondents' past and planned health care seeking patterns) (on file with author).

<sup>104</sup> *Id.* at 42.

<sup>105</sup> See, e.g., publications of the Alan Guttmacher Institute.

<sup>106</sup> Generally, parental consent provisions increase delay, cost and, ultimately, the health risk of abortions. See ACLU REPRODUCTIVE FREEDOM PROJECT, PARENTAL NOTIFICATION LAWS: THEIR CATASTROPHIC IMPACT ON TEENAGERS' RIGHT TO ABORTION 15 (1986); O'Keefe & Jones, *Easing Restrictions on Minors' Abortions Rights*, ISSUES SCI. & TECH. 74, 78 (1990). Less is known about how such provisions impact the poor and teenagers in low-income communities of color, in particular.

<sup>107</sup> The harmful effect of delay on health outcomes for women who ultimately receive an abortion has long been clear. See, e.g., Willard Cates et al., *The Effect of Delay and Method Choice on the Risk of Abortion Morbidity*, 9 FAM. PLAN. PERSP. 266 (1977). For an example of the kind of research that would begin to clarify the particular impact of waiting periods on low-income women of color, see generally Lupfer & Goldfarb Silber, *supra* note 93.

<sup>108</sup> For examples of such research, see Willard Cates, Jr., *The Hyde Amendment in Action: How Did the Restriction of Federal Funds for Abortion Affect Low-Income Women?*, 246 JAMA 1109 (1981); see also Benson Gold, *After the Hyde Amendment: Public Funding for Abortion in FY 1978*, 12 FAM. PLAN. PERSP. 131 (1980); James D. Shelton et al., *Abortion Litigation: Does Travel Distance Matter?*, 8 FAM. PLAN. PERSP. 260 (1976) (finding that distance is especially disadvantageous to blacks and most so to black teenagers).

and, also, must consult with researchers who can collect comprehensive data on the experiences of low-income women of color and can study how particular regulations will impact their ability to obtain services.

In anti-discrimination suits challenging hospital relocations and closures and in litigation against statutes that place restrictions on the provision of abortion services, courts have a duty to take seriously evidence of the ways in which structural barriers preclude meaningful access to care for the poor. Whatever the prospects for a fair hearing, however, we, as advocates, must find the means to present our cases more effectively. We must develop our proof to increase the probability of prevailing on behalf of our clients and, also, to serve the broader goals of litigation. Given the tremendous barriers of access faced by low-income people of color, the pervasiveness of discriminatory practices in the provision of health care, and the less than successful judicial record in health care access cases thus far, advocates must rethink strategies and conceive of new approaches. We should, for example, augment our information base and work with epidemiologists, other social scientists, demographers and medical specialists to develop the record. Then, with greater evidentiary power, we must build our cases in the courts by relating the realities faced by our clients.<sup>109</sup>

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<sup>109</sup> Critical legal theorists critique the concept of rights and often argue for a dialogue that stresses human needs. See discussions of the debate over the relevance of "rights" and "needs" in WILLIAMS, *supra* note 58, at 146-65; Delgado, *supra* note 96, at 303-07. The approach toward the presentation of evidence that is outlined in this paper combines these two strategies, although some may see them as diametrically opposed. As critical race theorists indicate, an explication of needs, alone, will not be persuasive to those who do not identify with low-income people of color. Patricia Williams writes, for example, "For blacks, describing needs has been a dismal failure as a political activity." WILLIAMS, *supra* note 58, at 151. This paper thus suggests continued use of the courts as one avenue in the struggle to give meaning to rights, but proposes, perhaps paradoxically, that a more persuasive depiction of needs is a necessary element of even this effort.

