

Made Whole: The Efficacy of Legal Redress for Black Women Who Have Suffered Injuries from Medical Bias

McKenzi B. Baker*

Kira Johnson died a preventable death when physicians at Cedars-Sinai Medical Center failed to adequately respond to hemorrhaging from what was supposed to be a routine cesarean section.¹ After waiting twelve hours for imperative attention that could have saved her life, Kira's husband was callously told that she was just not a priority.² Four hours later, the staff took her to surgery and found three and a half liters of blood in her abdomen. She bled to death.³ Before the procedure, Kira was in perfect health.⁴ She was fluent in five languages, had her pilot's license, and ran marathons.⁵ Despite her good health and accomplishments, a broken healthcare system killed her, depriving her husband and two children of her light for the rest of their lives.⁶ This tragic episode is not an anomaly for Black women.

As a Black woman, I find Kira's experience and the reality of inferior medical care for Black women especially disheartening. It frightens me to think that one of the happiest days of my life could also be the last due to rampant systematic prejudice, or that I could lose time to fight an illness that went undetected because of racial bias. Kira's experience could easily be

* Juris Doctor, Boston University School of Law. For helpful suggestions on earlier versions of this Article, I am grateful for Dean Angela Onwuachi-Willig. I am also grateful to Professor Khiara Bridges for being the first set of ears to hear this idea and encouraging me to pursue this topic. I am thankful for the CR-CL editing team who skillfully pushed me to bring out the best in this piece. I thank my parents, Willie and Kathy Baker as well as my siblings Memory and Ulrie, for teaching me to walk in faith, showering me with support, and allowing me to memorialize their experiences. Finally, I thank all the courageous Black women who have raised me, taught me, and supported me, and whom collectively serve as the inspiration for this piece. This Article is dedicated to them, Black women at large, and those who love them.

¹ See Meaghan Winter, *A Matter of Life & Death: Why Are Black Women in the U.S. More Likely to Die During or After Childbirth?*, ESSENCE, Oct. 2017, <https://www.essence.com/news/black-women-mortality-rate-child-deaths-united-states/>, archived at <https://perma.cc/JWE6-PKHJ>; see *Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.: Hearing Before the Subcomm. on Health of the H. Comm. On Energy and Com., 115th Cong. 19-20* (2018) (statement of Charles Johnson, Founder, 4Kira4Moms).

² Jamila Taylor, *Turning the Tide on America's Maternal Mortality Crisis*, THE CENTURY FOUNDATION (Mar. 10, 2020), <https://tcf.org/content/commentary/turning-tide-americas-maternal-mortality-crisis/?session=1>, archived at <https://perma.cc/HG95-MHY8>.

³ See Winter, *supra* note 1, at 108.

⁴ See Kira Johnson, Cedars-Sinai Los Angeles, CONSUMER WATCHDOG <https://www.consumerwatchdog.org/patient-safety/kira-johnson-cedars-sinai-los-angeles>, archived at <https://perma.cc/JF4K-KSQW>.

⁵ *Id.*

⁶ *Id.*

mine or my loved ones' experience. Matriarchs in my own family have had unfortunate encounters with the U.S. healthcare system when their voices were not heard and they suffered as a result. I challenge you to find a Black family without such experiences. Regardless of education level, pedigree, or social status, all Black women are vulnerable to the pervasive racist cracks in the U.S. healthcare system. This is intolerable. Black women have contributed too much to this country for their preventable pain and deaths to simply not be considered a priority.⁷

The United States is claimed to be one of the world's leaders in healthcare and medical innovation.⁸ Over the last decade, it has produced more than 50% of the world's new medicines and has spent more on healthcare than any other country.⁹ In spite of this innovation and investment, not all Americans reap the benefits of the healthcare system. Black women are more likely to have a negative experience than their white counterparts, even if they suffer the same injury.¹⁰ Black women who suffer injuries during medical procedures are more likely than white people to fall through the cracks of the legal system, ensuring that they are not "made whole." Being made whole is the idea, inherent in U.S. jurisprudence, that Americans have a substantive right to have their injuries remedied.¹¹ But even when Black women are harmed and seek justice, the legal remedies are frequently underwhelming and inaccessible. In a country with a legal system that endeavors to make injured parties whole, reproductive and medical justice for Black women remains broken. Instead, they face inadequate protections and limited redress.

Racial disparities are endemic in the U.S. healthcare system.¹² Black women are three to four times more likely to die from childbirth complica-

⁷ See generally *Black Culture Connection*, PBS, <http://www.pbs.org/black-culture/explore/black-women-in-history/>, archived at <https://perma.cc/5PTT-7SGY> (details the civil rights contributions of Black women like Harriet Tubman, Daisy Bates, Angela Davis); see also generally *Women of Color in STEM*, MARYVILLE U., <https://online.maryville.edu/blog/women-of-color-in-stem/>, archived at <https://perma.cc/E4R3-7B2F> (explains contributions of Black women to the science, technology, engineering and mathematics fields, including Katherine Johnson completion of the NASA calculations necessary for space missions).

⁸ See Grace-Marie Turner, *Though the U.S. Is Healthcare's World Leader, its Innovative Culture Is Threatened*, FORBES (May 23, 2012), <https://www.forbes.com/sites/gracemarieturner/2012/05/23/though-the-u-s-is-healthcares-world-leader-its-innovative-culture-is-threatened/>, archived at <https://perma.cc/3NLM-K2BJ>.

⁹ Irene Papanicolas, Liana Woskie & Ashish Jha, *Healthcare Spending in the United States and Other High-Income Countries*, 319 J. AM. MED. ASS'N 1024, 1024–25 (2018).

¹⁰ See *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 7, 2017), <https://www.npr.org/2017/12/07/568948782/Black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why/>, archived at <https://perma.cc/DFL4-VNFI>.

¹¹ See DAN B. DOBBS & CAPRICE L. ROBERTS, LAW OF REMEDIES: DAMAGES, EQUITY, RESTITUTION 21 (3d ed. 2018); Daniel Solomon, *Constraints on Damage Claims Under Title VI of the Civil Rights Act*, 3 LAW & INFO. 183, 184 (1985).

¹² See Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences between Blacks and Whites*, 113 PROC. NAT'L ACAD. SCI. U.S., 4296, 4296 (2016).

tions.¹³ They also die from breast cancer at a rate that is 40% higher than white women, despite both demographics being diagnosed with cancer at a similar rate.¹⁴ This disparity even extends to pain treatment, as Black patients in general are less likely to receive pain medication, and if given medication, receive less than non-Black patients.¹⁵

These disparities in medical treatment stem from racism that is deeply rooted and longstanding in the United States. The general belief, engrained in society and within the medical establishment, that Black people do not feel as much pain as their white counterparts is a remnant of that racism.¹⁶ The racial disparity also has a gendered component. In the past, society firmly believed women were weaker than men.¹⁷ But this characterization of women manifests differently depending on the race of the woman in question. For Black women, any gender-attributed vulnerability is cancelled out by the overpowering construct of Blackness.¹⁸ The way that society has construed Blackness is so all-encompassing that there is no room for any other identity; no room for vulnerability; no room for feeling pain.¹⁹

This unforgiving construction of Blackness explains why Black women are particularly vulnerable in the U.S. healthcare system and face unique problems that come with the intersectionality of being both Black and a woman.²⁰ Theories of the physiology of Black women's supposed abnormal ability to endure pain in childbirth can be traced back several centuries to the writings of European historians and travelers who visited Africa. These racist theories underpin the unacceptable rate of Black maternal mortality in

¹³ *Pregnancy-Related Deaths*, CTNS. FOR DISEASE CONTROL AND PREVENTION (Feb. 26, 2019), <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm>, archived at <https://perma.cc/N64P-P7SS>.

¹⁴ *Patterns and Trends in Age-Specific Black-White Differences in Breast Cancer Incidence and Mortality – United States, 1999-2014*, CTNS. FOR DISEASE CONTROL AND PREVENTION (Aug. 17, 2017), https://www.cdc.gov/cancer/dccp/research/articles/breast_cancer_rates_women.htm, archived at <https://perma.cc/BCZ6-WQLW>.

¹⁵ See Hoffman et al., *supra* note 12, at 4296.

¹⁶ See DEIRDRE C. OWENS, *MEDICAL BONDAGE: RACE, GENDER, AND THE ORIGINS OF AMERICAN GYNECOLOGY* 44 (Univ. of Ga. Press ed., 2017); see Sophie Trawalter, *Black Americans are Systematically Under-Treated for Pain. Why?*, U.VA. (Jun. 30, 2020), <https://bat-ten.virginia.edu/about/news/black-americans-are-systematically-under-treated-pain-why>; see Janice A. Sabin, *How We Fail Black Patients in Pain*, AM. ASS'N MED. COLLEGES (Jan. 6, 2020), <https://www.aamc.org/news-insights/how-we-fail-black-patients-pain>.

¹⁷ See Owens, *supra* note 16, at 24.

¹⁸ See Yevgenia Nayberg, *How are Black-White Biracial People Perceived in Terms of Race*, KELLOGGINSIGHT, <https://insight.kellogg.northwestern.edu/article/how-are-black-white-biracial-people-are-perceived-in-terms-of-race>, archived at <https://perma.cc/EJ2L-K8VG>.

¹⁹ See Janel George, *A Lesson on Critical Race Theory*, A.B.A., https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/civil-rights-reimagining-policing/a-lesson-on-critical-race-theory/, archived at <https://perma.cc/GET7-EE63>.

²⁰ See *Pregnancy-Related Deaths*, *supra* note 13. See generally KIMBERLE CRENSHAW, *ON INTERSECTIONALITY: ESSENTIAL WRITINGS* (2016). Intersectionality is a term coined by scholar Kimberle Crenshaw that refers to the interconnections between different social categorizations that a person may fall under.

the United States.²¹ As a paradigm of how racism has gone unchecked in the U.S. healthcare system, the United States' mismanagement of Black maternal mortality is a recurring example throughout this Article; however, it is not the only manifestation of injury to Black women caused by prejudicial healthcare that requires attention. Black women also disproportionately lose limbs, undergo unnecessary surgery, get misdiagnosed, and go untreated without appropriate recourse.²²

Accordingly, this Article seeks to address that reality and is divided into six main parts. Part I traces the racist history of medical bias in the United States. Part II explains the array of harms to Black women that result from pervasive bias in the U.S. healthcare system and require remedy. Part III discusses the obstacles that hinder Black women's access to resources that would help them successfully utilize legal recourses and obtain redress. Part IV sets forth the types of remedies available to Black women in the event that they suffer injury. Part V analyzes the efficacy of available legal recourses, such as medical malpractice cases and lawsuits arising from Title VI, and their ability to provide redress. Part VI proposes initiatives that would make it easier for Black women to present successful cases and thus, have better chances at being made whole. Through a critical understanding of medical racism's historical roots, the harms it causes, and the efficacy of recourses available to Black women for redress, we can evaluate what should be done to enhance their opportunities to access effective remedies.

I. THE RACIST HISTORY OF MEDICAL BIAS

The United States has a long history of believing that Black people are impervious to pain, which undergirds today's current practices of ignoring Black pain.²³ During the antebellum period, most physicians in the United States believed that Blackness carried a "so-called immutability."²⁴ Black bodies were hyper-sexualized, hyper-masculinized, and deemed to be medical "super bodies."²⁵ The medical consensus at the time endorsed, validated, and helped further promulgate these myths.²⁶ Delia Garlic, a formerly enslaved woman, recalled a time when her mistress was shocked that she fell unconscious after being struck by lumber.²⁷ Her mistress thought "[Delia's]

²¹ See Hoffman et al., *supra* note 12, at 4296; Owens, *supra* note 16, at 44.

²² See *Pregnancy-Related Deaths*, *supra* note 13; see also The Exchange, *When & Why Women & People of Color Face Lower Quality Healthcare & Worse Health Outcomes*, NEWS FROM N.H. and NPR (Sept. 16, 2019), <https://www.nhpr.org/post/when-why-women-people-color-face-lower-quality-healthcare-worse-health-outcomes#stream/0>, archived at <https://perma.cc/3DZS-UFFS>; see also Marco Huesch & Jason Doctor, *Factors Associated with Increased Cesarean Risk Among African American Women: Evidence from California, 2010*, 105 AM. J. PUB. HEALTH 956, 960 (2015).

²³ See Owens, *supra* note 16, at 44.

²⁴ *Id.* at 2.

²⁵ *Id.* at 44.

²⁶ *Id.* at 44.

²⁷ *Id.*

thick skull and cap of wool could take it better than that.”²⁸ Similarly, Harriet Jacobs wrote in her memoir that her master forced another enslaved woman to eat food that had killed his dog, believing that “the woman’s stomach was much stronger than the dog’s.”²⁹

In addition to disbelief of Black pain, early experiments in the United States also reflect disregard. Prominent examples include the gynecology testing done by Dr. James Sims and the Tuskegee Syphilis Experiment.³⁰ In the mid-1800s, Sims, who is often referred to as the “father of modern gynecology,” managed a women’s hospital on a slave farm in Mount Meigs, Alabama and treated enslaved women affected by vesicovaginal fistulae, a condition causing incontinence.³¹ Sims wrote that one subject felt extreme pain: “Lucy’s agony was extreme. She was much prostrated, and I thought that she was going to die.”³² Despite this pain, he performed his experiments without anesthesia. Afterward, the enslaved women on whom he operated were expected to continue carrying out their duties, including cooking, cleaning, picking vegetables, and nursing.³³ After perfecting his medical techniques on Black women without anesthesia, Sims then treated white women with anesthesia.³⁴ Because of his controversial additions to medicine and his inhumane use of human experimental subjects, Sims has been described as a “prime example of progress in the medical profession made at the expense of a vulnerable population.”³⁵

The Tuskegee Syphilis Experiment is another example of medical conduct sanctioned by the U.S. government that showed a disregard for Black pain. In 1932, the Tuskegee Institute and the Public Health Service began the “Tuskegee Study of Untreated Syphilis in the Negro Male” which lasted forty years.³⁶ This study involved six hundred Black men, two-thirds of whom had syphilis.³⁷ These Black men were told that they were being

²⁸ Owens, *supra* note 16, at 44.

²⁹ HARRIET JACOBS, INCIDENTS IN THE LIFE OF A SLAVE GIRL 13 (1861); *see also* Owens, *supra* note 16, at 44.

³⁰ *See* Owens, *supra* note 16, at 44; *see also* Rachel Zellars, *Black Subjectivity and the Origins of American Gynecology*, BLACK PERSPECTIVES (May 31, 2018), <https://www.aaihs.org/Black-subjectivity-and-the-origins-of-american-gynecology/>, *archived at* <https://perma.cc/WL2F-WEDS>.

³¹ *See* Owens, *supra* note 16, at 1. This condition was caused by the vaginal and anal tearing women suffered in childbirth.

³² Camila Domonoske, ‘Father of Gynecology,’ *Who Experimented on Slaves, No Longer on Pedestal in NYC*, NPR (Apr. 17, 2018), <https://www.npr.org/sections/thetwo-way/2018/04/17/603163394/-father-of-gynecology-who-experimented-on-slaves-no-longer-on-pedestal-in-nyc>, *archived at* <https://perma.cc/3YMB-7KAV>.

³³ Owens, *supra* note 16, at 2.

³⁴ *Id.*

³⁵ Sarah Spettel & Mark D. White, *The Portrayal of J. Marion Sims’ Controversial Surgical Legacy*, 185 J. UROLOGY 2424, 2425 (2011).

³⁶ *The Tuskegee Timeline*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/tuskegee/timeline.htm>, *archived at* <https://perma.cc/R9N2-E9Y6>.

³⁷ *Id.*

treated for “bad blood.”³⁸ In the mid-1940’s it became known in the medical community that penicillin was the recommended treatment for syphilis.³⁹ Despite this consensus, the Tuskegee Institute did not administer penicillin to the study’s “participants” for twenty-five years, and did not give them a choice to quit the study.⁴⁰ In July 1972, a reporter wrote a story that exposed the syphilis experiments in the *New York Times*.⁴¹ The ensuing public outrage led to the Assistant Secretary for Health and Scientific Affairs appointing an Ad Hoc Advisory Panel, including, among others, the executive director of the National Medical Association, attorneys, and professors.⁴² This panel deemed the study “ethically unjustified” and recommended the researchers cease their experiments on the Black men.⁴³ In 1974, the National Research Act was signed into law, retroactively addressing the issue of protecting human subjects.⁴⁴ For decades afterward, the Tuskegee Syphilis Experiment and its public outcry stimulated higher ethical standards in biomedical research.⁴⁵ However, the experiment also became the archetypical example for explaining why Black people tend to distrust doctors.⁴⁶ While the Tuskegee Syphilis Experiment is not the singular impetus for Black distrust of the U.S. healthcare system,⁴⁷ the accumulation of demonstrated disregard for the Black community in medical testing over centuries, as exemplified in Sims’ gynecology studies and the Tuskegee experiment, deepens that distrust and, in turn, affects the quality of care that Black people receive.

This assumption that Black people feel less pain still persists in modern times and has been described as the “racial empathy gap”—the lack of empathy for pain experienced by Black people.⁴⁸ For example, in one recent

³⁸ *Id. But cf.* Robert M. White, *The Tuskegee Syphilis Study and Informed Consent*, 42 ANNALS OF EMERGENCY MED. 430, 431 (2003) (Informed consent, the duty of physicians to disclose to the patient the risks, benefits, and alternatives of a procedure, was not obtained during the Tuskegee Syphilis Experiment, but this source suggests that informed consent was not typically obtained in research studies conducted in the 1930s and 1940s).

³⁹ See *The Tuskegee Timeline*, *supra* note 36.

⁴⁰ *Id.*

⁴¹ Jean Heller, *Syphilis Victims in the U.S. Study Went Untreated for 40 Years*, N.Y. TIMES (Jul. 26, 1972), <https://www.nytimes.com/1972/07/26/archives/syphilis-victims-in-us-study-went-untreated-for-40-years-syphilis.html>, archived at <https://perma.cc/L7UY-D6RB>.

⁴² See *The Tuskegee Timeline*, *supra* note 36.

⁴³ *Id.*

⁴⁴ See *The U.S. Public Health Service Syphilis Study at Tuskegee: Research Implications*, CTNS. FOR DISEASE CONTROL AND PREVENTION (Feb. 2, 2020), <https://www.cdc.gov/tuskegee/after.htm>, archived at <https://perma.cc/WVF8-ECJL>.

⁴⁵ *Id.*

⁴⁶ See April Dembosky, *Stop Blaming Tuskegee, Critics Say. It’s Not an ‘Excuse’ for Current Medical Racism*, NPR (Mar. 23, 2021), <https://www.npr.org/sections/health-shots/2021/03/23/974059870/stop-blaming-tuskegee-critics-say-its-not-an-excuse-for-current-medical-racism>, archived at <https://perma.cc/V3AX-UCT5>.

⁴⁷ See Dembosky, *supra* note 46.

⁴⁸ *Study: Whites think Black People Feel Less Pain*, NPR (Jul. 11, 2013) <https://www.npr.org/templates/story/story.php?storyId=201128359>, archived at <https://perma.cc/6JX6-JZJ9>.

study, researchers tested how people perceived the pain of different racial groups by showing videos of participants being pricked by different instruments, including a needle that appeared to be painful and an eraser.⁴⁹ When the test subjects saw white people receiving the needle stimulus, they displayed a much more dramatic response than when they saw Black people receiving that same stimulus.⁵⁰ A subsequent experiment tested nurses and nursing students which showed the same result: all participants, both white and Black, assumed that Black people felt less pain than white people.⁵¹

These studies reflect the reality where Black patients continue to receive less pain medication than their white counterparts and their complaints of pain are not taken as seriously. When I was a child, my father went to an orthodontist for a bone graft while my mother took care of me and my siblings at home. About fifteen minutes into the procedure, the anesthesia wore off and he began to feel excruciating pain. He repeatedly informed the orthodontist of his agony. Instead of pausing to assess what had gone wrong, the doctor disregarded my father's complaints entirely and continued the procedure. At a certain point, my father could no longer withstand the pain, so he ended the procedure. The doctor failed to acknowledge my father's pain and did not show any remorse about the situation. The doctor's substandard competence in addressing my father's pain eventually caused him to lose the tooth entirely and the ability to chew on the right side of his mouth.

Black people suffering through disregarded pain and receiving less pain relief than white people is a result of various factors, including unequal access to healthcare and an incorrect association within the medical community between Black people and drug use.⁵² For example, Black people typically have less health insurance coverage and face larger hurdles to get that health insurance, a gap that has not narrowed over time.⁵³ Even after Black people get access to healthcare coverage, there are geographical challenges such as "pharmacy deserts."⁵⁴ Although pharmacies can give basic healthcare to those who cannot afford to see a doctor,⁵⁵ a disproportionate level of low-income Black neighborhoods lack full access to pharmacies, making it harder to access relief.⁵⁶

Additionally, Black patients are less likely than white patients to receive any opioids and more likely to receive lower doses of opioids, despite

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² See Hoffman et al., *supra* note 12, at 4296.

⁵³ See UNDERSTANDING RACIAL AND ETHNIC DIFFERENCES IN HEALTH IN LATE LIFE: A RESEARCH AGENDA 92 (Rodolfo A. Bulatao & Norman B. Anderson eds., 2004).

⁵⁴ Dima M. Qato, Martha L. Daviglus, Jocelyn Wilder, Todd Lee, Danya Qato & Bruce Lambert, 'Pharmacy Deserts' Are Prevalent in Chicago's Predominantly Minority Communities, *Raising Medication Access Concerns*, 33 HEALTH AFFAIRS 1958, 1958 (2014).

⁵⁵ *Id.*

⁵⁶ *Id.* In 2012 in Chicago, there were disproportionately more pharmacy deserts in Black communities.

higher pain scores, despite studies that white patients are more likely to endanger themselves with drug misuse.⁵⁷ In a study of almost one million children diagnosed with appendicitis, Black patients were less likely than white patients to receive medication for pain at the moderate level.⁵⁸ They were also less likely to receive opioids, the standard treatment for severe pain.⁵⁹ The prejudicial association that Black people are more likely than white people to misuse drugs while being less likely to feel pain is used as a basis for other types of mistreatment. For example, physicians use prejudice on drug use as a “cognitive short cut” to reduce the time a physician spends on a patient.⁶⁰ Because of the short cut and less time with Black patients, the physician’s thought process becomes automated and increases the likelihood that they disregard the reality of the patient in front of them.⁶¹ By relying on internal biases, automation of care negatively affects the quality of health-care and relief physicians provide.⁶²

Black women are not impervious to pain, contrary to historical assumptions. Looking at the background of medical racism in the United States provides the necessary foundation for understanding where legal recourses fall short in protecting Black women and holding bad actors in the medical community accountable. Persistent racism, combined with obstacles to accessing legal resources, places Black women in a dangerous world of harms and impairs their path to legal redress.⁶³

II. THE HARMS TO BE REDRESSED

In order to assess the efficacy of legal recourses, we must understand the harms resulting from medical bias that Black women face, specifically emotional and psychological harm, generational harm, physical harm, and economic harm. The emotional and psychological harms endured by Black women undermine the very core of the U.S. medical field by compromising the patient-provider relationship. Similarly, long-lasting generational harm is continuously swept under the rug even though it demands attention from physicians and other medical professionals. Economic harm and physical harm are both generally more visible, but they are still viable threats to the well-being of Black women. Each type of harm—emotional and psychological, generational, physical, and economic harm—is explored in turn herein.

⁵⁷ See Ronald Wyatt, *Pain and Ethnicity*, 15 AM. MED. ASS’N J. ETHICS 449, 450 (2013).

⁵⁸ Hoffman et al., *supra* note 12, at 4296.

⁵⁹ *Id.*

⁶⁰ See Stephanie Sun and Bruce White, *Pharmacist and Prescriber Responsibilities for Avoiding Prescription Drug Misuse Forum*, 23 AM. MED. ASS’N J. ETHICS 471, 474 (2021). Physicians use cognitive short cuts to come to a decision quickly.

⁶¹ See *id.* at 474–75.

⁶² See *id.*

⁶³ In this Article, recourses refer to types of lawsuits that can be brought, arising from causes of action. Resources refer to legal aid outside of those lawsuits.

A. *Emotional and Psychological Harm*

Emotional and psychological harm compromise the patient-provider relationship, a core value of the medical field, by obstructing necessary patient trust.⁶⁴ Emotional and psychological harm refers to feelings of not being valued, fear of hospitals or physicians, and harm to one's dignity. Some medical professionals define dignity as "the intrinsic, unconditional value of all persons."⁶⁵ Emotional and psychological harm can be triggered by a single event, ongoing events, or generational harm.⁶⁶ Patients who suffer from this type of harm may find it hard to absorb medical information due to feeling overwhelmed or the impulse to become defensive.⁶⁷ Psychological harm can manifest through depression, worry, loss of self-confidence, and a shattered sense of security.⁶⁸ If Black women see a physician, they often worry that their complaints will be dismissed. They often do not feel secure.⁶⁹

Many years of subpar medical care has sent a clear message about the value of Black women in the eyes of medical professionals. Subpar care also occurs across different diseases and diagnoses. In diabetes care, it is more likely for a Black patient to be recommended to have their limbs amputated than it is for a white patient experiencing the same symptoms. Black women are shown that a white woman's leg is worth the extra effort to protect, but the leg of a Black woman is not. This statistic deals an emotional and psychological blow to the Black woman.⁷⁰ Additionally, when presented with pelvic pain, Black women have suffered ineffective treatment due to being more likely to be misdiagnosed with sexually transmitted pelvic inflammatory diseases, while white women were more likely to be correctly diagnosed with endometriosis.⁷¹ This misdiagnosis is likely influenced by the

⁶⁴ See generally Domenico Montemurro, et. al., *Medical Professional Values and Education: A Survey on Italian Students of the Medical Doctor School in Medicine and Surgery*, 5 N. AM. J. MED. SCI. 134, 137 (2013).

⁶⁵ IHI Multimedia Team, *To Prevent Patient Harm, Practice Respect and Deliver Dignity*, INST. FOR HEALTHCARE IMPROVEMENT (Aug. 14, 2018), <http://www.ihl.org/communities/blogs/to-prevent-patient-harm-practice-respect-and-deliver-dignity>, archived at <https://perma.cc/DM95-GRD6>.

⁶⁶ See Lawrence Robinson, Melinda Smith & Jeanne Segal, *Emotional and Psychological Trauma*, HELP GUIDE (Feb. 2020), <https://www.helpguide.org/articles/ptsd-trauma/coping-with-emotional-and-psychological-trauma.htm>, archived at <https://perma.cc/A8TX-46HP>.

⁶⁷ Scott Janssen, *Considering Racial Trauma in African American Underuse of Hospice/Palliative Care*, SOCIAL WORK TODAY, https://www.socialworktoday.com/archive/exc_0219.shtml, archived at <https://perma.cc/S8EJ-Y9SQ>.

⁶⁸ See *Types of Harm*, U. OF VA., <https://research.virginia.edu/types-harm>, archived at <https://perma.cc/9UX5-G933>.

⁶⁹ See Yasmin Anwar, *Why Middle-Class Black Women Dread the Doctor's Office*, BERKELEY NEWS (Jan. 18, 2019), <https://news.berkeley.edu/2019/01/18/invisiblevisits/>, archived at <https://perma.cc/9WTB-LHGX>; see also *Gaslighting in Women's Health: No It's Not Just In Your Head*, NORTHWELL HEALTH, <https://www.northwell.edu/katz-institute-for-womens-health/articles/gaslighting-in-womens-health>, archived at <https://perma.cc/WFS4-DLML>.

⁷⁰ See The Exchange *supra* note 22.

⁷¹ See *id.*

hypersexualization of Black women,⁷² which, as discussed earlier, is a remnant of the racist roots of United States. By perpetuating this horrid legacy, the emotional harm resulting from these misdiagnoses is deepened, which even further compromises the patient-provider relationship.

Trust is an important element of the patient-provider relationship, but years of being overlooked and underserved has made it difficult for Black women to have confidence in their physicians. Medical bias results in emotional and psychological injuries on the psyche of Black women. Black women are left feeling like they are undervalued in a field that made academic strides on their backs, a sentiment that can be hard to properly redress due to the intangible nature of emotional and psychological harm.

B. *Generational Harm*

Generational harm as refers to what is often known as “historical trauma” regarding longstanding distrust toward the medical field.⁷³ Historical trauma occurs when a certain group is imprinted with awareness of traumatizing historical events to which their ancestors were exposed.⁷⁴ Ancestors who directly experienced trauma can pass this stress down to their descendants as generational harm.⁷⁵ This residual intergenerational trauma has caused harm, including emotional, psychological, and physiological harm, for individual Black women and the Black community as a whole.

For example, Black women who experience stress from high levels of racial discrimination are “[three] times more likely to give birth prematurely, and [five] times more likely to have a low birth-weight baby.”⁷⁶ This is because stress produces cortisol which can reduce blood flow to the fetus and restrict the baby’s growth.⁷⁷ Babies born with a low birth weight could be at risk for several health complications,⁷⁸ so the trauma that the mother experiences is thus passed down to another generation via the child.⁷⁹

Because of generational trauma, many members of Black families are adamant about not going to a hospital or do not trust a physician’s diagnosis.⁸⁰ Black communities’ distrust of medical science was especially apparent in conversations about the COVID-19 vaccine during 2020, as they were disproportionately more hesitant to get a vaccine than other U.S. ethnic and

⁷² See *id.*

⁷³ See *Types of Harm supra* note 69.

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Low Birth Weight Babies and Black Women: What’s the Connection?*, BLACK WOMEN’S HEALTH IMPERATIVE (Jul. 23, 2017), <https://bwhi.org/2017/07/23/low-birth-weight-babies-black-women-connection/>.

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ See generally Elizabeth A. Jacobs, et. al., *Understanding African Americans’ Views of the Trustworthiness of Physicians*, 21 J. GEN. INTERN MED. 642, 642–47 (Jun. 2006).

racial groups.⁸¹ Although that distrust is understandable given the history of Black people being exploited in experiments,⁸² the resulting resistance to vaccination during the spread of the deadly disease caused Black people to be disproportionately more likely to die from contracting COVID-19.⁸³ They were also sometimes blamed for spreading the disease by people like former Leelanau County Road Commissioner, Tom Eckerle who asserted “[w]ell this whole thing is because of them [racial slur] down in Detroit.”⁸⁴

When the medical community embarked on a sudden trust-building campaign in response to the distrust of vaccines in Black communities,⁸⁵ Dr. Kizzmekia Corbett, a Black woman, made headlines for pathogen research she had been engaged in for several years.⁸⁶ It was a well-deserved spotlight, but it was overdue. The systemic racism causing underrepresentation of Black people in medical fields has been tolerated by the U.S. medical community for years.⁸⁷ The passive continuation of generational harm inflicted upon the Black community inspired no substantial movements or changes. Yet, when Black trauma transcends the Black community and affects the

⁸¹ James Doubek & David Greene, *Black People are More Hesitant about a Vaccine. A Leading Nurse Wants to Change That*, NPR (Nov. 24, 2020), <https://www.npr.org/sections/coronavirus-live-updates/2020/11/24/938440381/Black-people-are-more-hesitant-about-a-vaccine-a-leading-nurse-wants-to-change-t>, archived at <https://perma.cc/X8EE-ZHT7>.

⁸² See Owens, *supra* note 16, at 44.

⁸³ See *COVID-19 Vaccine Equity for Racial and Ethnic Minority Groups*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Jul. 19, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/vaccine-equity.html>, archived at <https://perma.cc/8A7X-DWQK>; see Shanoor Seervai, *Why Are More Blacks Dying of COVID-19?*, COMMONWEALTH FUND (Jun. 26, 2020), <https://www.commonwealthfund.org/publications/podcast/2020/jun/why-are-more-black-americans-dying-covid-19>, archived at <https://perma.cc/X6MU-NLYF>.

⁸⁴ John Flesher, *Michigan County Official Resigns After Doubling Down on N-word, Says He's Not Racist*, ASS'N PRESS (Aug. 7, 2020), <https://apnews.com/article/virus-outbreak-race-and-ethnicity-michigan-detroit-racial-injustice-e115b3987f16e9610f6956bcb939c41>, (last visited Jan. 11, 2022).

⁸⁵ See Adam Cancryn, *Biden's Vaccine Push Fails to Gain Traction with African Americans*, POLITICO (Jun. 7, 2021), <https://www.politico.com/news/2021/06/07/vaccine-equity-black-americans-biden-491973>, archived at <https://perma.cc/5P6Z-M7TX> (describing how the White House's COVID-19 Health Equity Task Force recommendation to build trust in the vaccine has not been doing enough to “win over” Black people. Additionally, a series of initiatives were employed aiming “in large part at convincing more Black people to seek out the shot”); see also Christopher Booker & Connie Kargbo, *Inside the Attempt to Build Trust About the COVID-19 Vaccine in Black Communities*, PBS (Dec. 12, 2020), <https://www.pbs.org/newshour/show/inside-the-attempt-to-build-trust-about-the-covid-19-vaccine-in-black-communities>, archived at <https://perma.cc/QZ4P-WKDN>.

⁸⁶ See Laura Romero, *Sony Salzman & Kaitlyn Folmer, Kizzmekia Corbett, an African American Woman, is Praised as Key Scientist Behind COVID-19 Vaccine*, ABC NEWS (Dec. 13, 2020), <https://abcnews.go.com/Health/kizzmekia-corbett-african-american-woman-praised-key-scientist/story?id=74679965>, archived at <https://perma.cc/2BVZ-V4L9>.

⁸⁷ See Cary Funk & Kim Parker, *Blacks in STEM Jobs are Especially Concerned about Diversity and Discrimination in the Workplace*, PEW RES. CTR. (Jan. 9, 2018), <https://www.pewresearch.org/social-trends/2018/01/09/blacks-in-stem-jobs-are-especially-concerned-about-diversity-and-discrimination-in-the-workplace/>, archived at <https://perma.cc/842H-72DT>; see also Lanair Amaad Lett, H. Moses Murdock & Whitney U. Orji, *Trends in Racial/Ethnic Representation Among US Medical Students*, JAMA NETWORK OPEN. (Sep. 4, 2019), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2749233>, archived at <https://perma.cc/3783-V8GA>.

greater community at large, U.S. institutions suddenly seem to understand how to leverage the power of representation. In the face of such convenient timing, Black people are warranted in wondering whether trust-building campaigns during the pandemic have genuine motives to repair the legacy of generational harm or if U.S. medical institutions are doing just enough to get past a state of emergency and will sweep Black issues back under the rug once the emergency passes.

It is great to build trust by honoring Black women at the forefront of innovation in medical research. But it is unfortunate that the United States did not invest in more authentic and consistent efforts to build trust *before* the emergency of COVID-19. As the pandemic painfully demonstrated, Black suspicion of the medical community passed through generations is not only dangerous to Black people, but also has the ability to undermine the medical profession's efforts to protect society as a whole. Convenient trust-building efforts from the medical community with questionable motives foster distrust through Black generations, but consistent efforts that have genuine motives will be more effective in addressing generational harms.⁸⁸

C. *Physical Harm*

Physical harm refers to Black women who sustain tangible injuries such as pain, illness, impairment, or death caused by medical bias. As an example, if a physician dismisses a Black woman's complaints, she may have to experience extra weeks of pain and suffering, potentially contracting new illnesses. In more extreme cases, such as that of Kira Johnson, lack of care or inadequate care can cause death. Black pregnancy care is one example. The potential for physical harm produced from medical bias is a harrowing reality for many pregnant Black women, not only because they are three to four times more likely to die from childbirth complications,⁸⁹ but also because physicians are more likely to perform invasive procedures on them.⁹⁰ Black women are significantly more likely to have a cesarean section delivery than other women.⁹¹ One 2010 study suggests that Black women face challenges, such as perceived discrimination and lack of mutual trust,⁹² in communicating their needs and preferences for maternal care to physicians, or that those physicians are less likely to act on the preferences that are communicated.⁹³

⁸⁸ See Booker & Kargbo, *supra* note 85.

⁸⁹ See *Pregnancy-Related Deaths*, *supra* note 13.

⁹⁰ See Huesch & Doctor, *supra* note 22, at 956.

⁹¹ Wyatt, *supra* note 57, at 450.

⁹² See Jamie A. Mitchell and Ramona Perry, *Disparities in Patient-Centered Communication for Black and Latino Men in the U.S.: Cross-Sectional Results From the 2010 Health and Retirement Study*, 15 PLoS ONE, Sept. 2020, at 3 (noting that when Black patients interact with health providers there is evidence that "physicians exhibit less patient-centered communication with them compared to White patients, such as using a harsher tone or providing less time for patients to ask questions; often as a result of implicit racial bias").

⁹³ *Id.*

This breakdown in communication can cause more serious physical injuries. Other examples of physical pain that, but for racist bias, could be avoided include symptoms resulting from misdiagnosis. In the aforementioned appendicitis study, Black patients were less likely than white patients to receive pain medication for pain at the moderate level, and they were also less likely to receive opioids—the standard treatment for pain at the severe level.⁹⁴ As a result, the Black patients endure preventable physical pain because they don't receive appropriate pain relief.

Physical injury and pain are avoidable harms suffered when physicians adhere to stereotyped perceptions of Black patients and given the history of the medical field's blindness to their pain, Black women are especially vulnerable to tangible injuries.

D. Economic Harm

Economic harm is financial loss due to medical discrimination. Economic harm is one of the more visible harms and is especially burdensome for Black women, as they are more likely than most demographics to fall within a low-income status.⁹⁵ Roughly 60% of bankruptcies are caused by medical bills, a testament to how expensive medical treatment can be.⁹⁶ If prejudice causes a physician to overlook a medical issue, and that medical issue ripens into a serious injury, Black women still have to pay for all the unproductive doctor visits and incur avoidable economic harms from their financial loss.⁹⁷

Attempting to recoup financial losses from medical discrimination through legal recourse is costly as well; there are expenses associated with utilizing legal recourses.⁹⁸ Medical malpractice cases are expensive to pursue because many cases require expert witnesses, who can charge hundreds or thousands of dollars per hour for their services.⁹⁹ As expert witnesses often spent 20 to 30 hours preparing and testifying for a medical malpractice claim, these expenses can easily add up to a substantial sum.¹⁰⁰ Now, compare the average cost of litigation with the average net worth of a Black family. In 2016, the net worth of a typical Black family was \$17,600 with

⁹⁴ Hoffman et al., *supra* note 12, at 4296.

⁹⁵ See Table 1 and Table 2.

⁹⁶ See Kelley Long, *What I Learned from Disputing a Medical Bill*, FORBES (Jun. 30, 2016), <https://www.forbes.com/sites/financialfinesse/2016/06/30/what-i-learned-from-disputing-a-medical-bill/?sh=42542794416f>, archived at <https://perma.cc/V24B-7FPB>.

⁹⁷ *Id.*

⁹⁸ David Goguen, *How Much Will It Cost to Bring a Medical Malpractice Claim?*, ALL-LAW, <https://www.alllaw.com/articles/nolo/personal-injury/cost-bring-claim.html>, archived at <https://perma.cc/V4AR-NJMR>.

⁹⁹ *Id.*

¹⁰⁰ *Id.* As a result of these expenses, many medical malpractice claims are pursued under a type of contingency fee. *Id.*

many Black families having a negative net worth.¹⁰¹ One experience with a biased physician resulting in injury can wipe out a Black woman's net worth or result in debt. Further, legal expenses are typically still owed even in a losing case.¹⁰² Economic harm is difficult to avoid, but is the easiest harm to redress through legal recourse. Money is replaceable. In the meantime, Black women who are harmed economically have to deal with the financial loss until the losses can be recouped.

III. OBSTACLES TO LEGAL RESOURCES

The United States' background of medical racism has resulted in a world of harms facing Black women, leaving them prone to medical injury and in need of legal redress. Unfortunately, helpful resources are often out of reach. This was the case for one woman, Elizabeth Liggon-Redding, who was unable to utilize professional counsel that could have made a difference in the outcome of her medical malpractice complaint.¹⁰³ Although she requested the appointment of pro bono counsel, she did not meet the district court's standard for appointing pro bono counsel and the court determined that Liggon-Redding had "the ability to represent herself."¹⁰⁴ The court ultimately found her claims lacked merit, so her complaint was unsuccessful after she was denied the free legal aid.¹⁰⁵ Legal resources should be more accessible to Black women like Liggon-Redding. However, hurdles such as (A) conflation of the criminal justice system and civil legal systems, (B) economic constraints, and (C) a perceived duty of self-sufficiency can keep those services out of reach of Black women. Accordingly, Section A explains how the conflation of the criminal justice and civil legal systems deters utilization of the civil system. Section B describes how Black women are more likely to be constrained economically and how those economic constraints make it difficult to access legal resources, and Section C discusses how Black women's self-sufficiency through the "superwoman complex" dissuades them from seeking legal assistance.

¹⁰¹ William Darity, Jr. et al., *What We Get Wrong about Closing the Racial Wealth Gap*, SAMUEL DUBOIS COOK CTR. ON SOC. EQUITY 1, 2 (Apr. 2018), <https://socialequity.duke.edu/wp-content/uploads/2020/01/what-we-get-wrong.pdf>, archived at <https://perma.cc/RE4V-LL4G>; see also Kriston McIntosh, Emily Moss, Ryan Nunn & Jay Shambaugh, *Examining the Black-White Wealth Gap*, BROOKINGS (Feb. 27, 2020), <https://www.brookings.edu/blog/up-front/2020/02/27/examining-the-black-white-wealth-gap/>, archived at <https://perma.cc/X94M-5TWF>.

¹⁰² Cara O'Neill, *Attorney Fees: Does the Losing Side Have to Pay?*, NOLO, <https://www.nolo.com/legal-encyclopedia/attorney-fees-does-losing-side-30337.html>, archived at <https://perma.cc/KC5U-KP7T>.

¹⁰³ *Liggon-Redding v. Voorhees*, No. 14-3139, 2014 U.S. Dist. LEXIS 108601, at *1-2 (D.N.J. Aug. 7, 2014) (alleging Plaintiff underwent avoidable surgery because her heart problems were not taken seriously and her complaints of chest and stomach pains went undiagnosed).

¹⁰⁴ *Id.* at *16-17.

¹⁰⁵ *Id.*

A. *Conflation of the Criminal Justice and Civil Legal Systems*

Legal literacy is a fundamental understanding of the legal system, legal rights, and obligations; the lack of which can result in lower access to legal assistance.¹⁰⁶ The erroneous conflation of the criminal justice and civil legal systems is demonstrative of a lack of legal literacy. Minority groups tend to have a lower understanding of the legal system and are thus less likely than their counterparts to successfully utilize help when they are experiencing a civil rights issue.¹⁰⁷ In fact, they are likely to incorrectly conflate the civil legal system with the criminal justice system.¹⁰⁸ Black respondents in one study believe that the civil and criminal justice systems are the same system, functioning with the same government actors.¹⁰⁹ This study exposed a connection between respondents' negative past experiences with the criminal justice system and subsequent decisions to not seek help for civil rights issues.¹¹⁰

For example, when asked how they would “go about finding a lawyer if they were evicted,” many said they would seek assistance from a public defender, a resource available in criminal trials but not civil ones.¹¹¹ One respondent specifically said, “[w]ell, if I really needed a lawyer against my landlord I could get one of those public defenders for free.”¹¹² Another said, “I’m not in the business of going to lawyers, but if I needed to, there are public defenders available for free.”¹¹³ Further, when asked a specific question about the differences between the civil and criminal justice systems, 78% of respondents reported to not know the difference.¹¹⁴

Eighty-seven percent of Black people acknowledge that the criminal justice system treats them less fairly than their white counterparts.¹¹⁵ Thus, a past negative experience within the criminal justice system, such as an unrelenting prosecutor, makes Black participants more resistant to seek help with matters in civil legal systems.¹¹⁶ This also speaks to the lack of faith the

¹⁰⁶ Brett Freudenberg, *Beyond Lawyers: Legal Literacy for the Future*, 45 AUSTL. BUS. L. REV. 387, 389–401 (2017) (noting that legal literacy refers to an understanding of one’s legal rights and obligations).

¹⁰⁷ See Sara S. Greene, *Race, Class, and Access to Civil Justice*, 101 IOWA L. REV. 1263, 1263 (2016) (also noting that this phenomenon is more pronounced among Black people with lower income levels).

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.* at 1289.

¹¹² *Id.*

¹¹³ *Id.* at 1290.

¹¹⁴ *Id.* at 1289.

¹¹⁵ John Gramlich, *From Police to Parole, Black and White Americans Differ Widely in Their Views of Criminal Justice System*, PEW RESEARCH CTR. (May 21, 2019), <https://www.pewresearch.org/social-trends/2019/04/09/race-in-america-2019/#majorities-of-black-and-white-adults-say-blacks-are-treated-less-fairly-than-whites-in-dealing-with-police-and-by-the-criminal-justice-system>, archived at <https://perma.cc/B4KR-RPC6>.

¹¹⁶ Greene, *supra* note 107, at 1266–67.

Black community has in the law. It is common knowledge that the criminal justice system adversely affects Black people.¹¹⁷ If Black people who have been disenfranchised by the criminal justice system cannot distinguish between the two systems, it is only natural that they would not feel comfortable engaging with civil systems to pursue their rights.¹¹⁸ When the two are conflated, the infamous sins of the criminal justice system further stain the civil legal system, which has its own prejudicial sins to contend with,¹¹⁹ and becomes a deterrent to Black women's utilization of civil remedies.

B. Economic Constraints

When compared with other demographics, Black women are disproportionately more likely to be near low-income status and fall into the "justice gap," a term representing the difference between legal needs and legal services available.¹²⁰ Table 1 below demonstrates this by showing the relative high rate of Black women living near or below the poverty line. In 2019, the U.S. Census Bureau determined the federal poverty threshold to be \$13,300.¹²¹ Individuals with income less than twice the federal poverty threshold are commonly considered to be within low-income status.¹²² Accordingly, an individual who made less than \$16,600 in 2019 would be considered to be within low-income status.

¹¹⁷ See generally MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS* (2010) (analyzing the disproportionate effects of mass incarceration on Black men); see also generally Connor Maxwell and Danyelle Solomon, *Mass Incarceration, Stress and Black Infant Mortality: A Case Study in Structural Racism*, CTR. FOR AM. PROGRESS 1, 2 (Jun. 5, 2018), <https://www.americanprogress.org/issues/race/reports/2018/06/05/451647/mass-incarceration-stress-Black-infant-mortality/>, archived at <https://perma.cc/B938-8ZYC> (explaining the criminal justice system affects millions of Black women and children).

¹¹⁸ There are thirty-five countries in the Americas. In this Article, terms like America and American refer to the United States and its residents.

¹¹⁹ See, e.g., Child Welfare Information Gateway, *Child Welfare Practice to Address Racial Disproportionality and Disparity*, U.S. DEP'T. OF HEALTH AND HUM. SERVICES (2021), https://www.childwelfare.gov/pubpdfs/racial_disproportionality.pdf (noting that Black families are both overrepresented in reports of suspected maltreatment and are subject to child protective services investigations at higher rates than other families).

¹²⁰ Rebecca Buckwalter-Poza, *Making Justice Equal*, CTR. FOR AM. PROGRESS 2 (Feb. 25, 2020), <https://www.americanprogress.org/issues/criminal-justice/reports/2016/12/08/294479/making-justice-equal/>, archived at <https://perma.cc/8ZGJ-VS54>.

¹²¹ See *Poverty Thresholds*, U.S. CENSUS BUREAU (last revised Feb. 20, 2021), <https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html>, archived at <https://perma.cc/7ACJ-AA32>.

¹²² Often, federal programs will use this percentage limitation or similar ones to denote eligibility requirements. See, e.g., Federal Poverty Guidelines, MASSLEGALSERVICES (Jan. 19, 2021), <https://www.masslegalservices.org/content/federal-poverty-guidelines-2021>, archived at <https://perma.cc/F9Z8-RWTG>; see, e.g., Yang Jiang, Mercedes Ekono, Curtis Skinner, *Basic Facts about Low-Income Children*, NAT'L CTR. CHILD POVERTY (Feb. 2016), <https://www.nccp.org/publication/basic-facts-about-low-income-children-children-under-18-years-2014/>, archived at <https://perma.cc/A4FE-8JRZ>.

TABLE 1 – *Percentage of full-time wage and salary workers near low-income status in 2019 by selected demographic characteristics [in thousands]*¹²³

<i>Characteristic</i>	<i>Number of workers with annual average earnings of less than \$18,200.00</i>	<i>Total Employed</i>	<i>Percentage</i>
White			
Men	1,193	51,110	2.33%
Women	1,658	39,084	4.24%
Black or African American			
Men	288	7,378	3.90%
Women	521	8,081	6.45%
Asian			
Men	96	4,334	2.22%
Women	114	3,563	3.20%
Hispanic or Latino ethnicity			
Men	452	12,611	3.58%
Women	596	8,616	6.92%

Black women had the second highest percentage—by less than half a percent—of workers near low-income status in 2019. Because Black women are more likely to be low-income status and to need legal services, they are apt to not receive adequate legal help, and therefore, fall between the cracks.¹²⁴ An American Bar Association study found that 47% of low-income individuals experience one or more civil rights issues, yet only 25% of them seek legal advice, and the remaining 75% do not pursue any help at all.¹²⁵ Many low-income individuals believe that they do not have the money for a good lawyer since the public does not have a general right to counsel in civil matters.¹²⁶ The inability to afford counsel contributes to the justice gap.¹²⁷

¹²³ See Highlights of Women’s Earnings in 2019, U.S. BUREAU OF LAB. STAT., 1, 42 tbl.6 (2020), <https://www.bls.gov/opub/reports/womens-earnings/2019/pdf/home.pdf>, archived at <https://perma.cc/5XBR-3QKB>. This table was derived from data in Table 6 by multiplying “usual weekly earnings” by fifty-two. Note that more individuals could have been considered low-income status than are represented in Table 1, seeing that the U.S. Bureau of Labor Statistics data does not specifically account for incomes between \$16,600 and \$18,200.

¹²⁴ See Buckwalter-Poza, *supra* note 120.

¹²⁵ Legal Needs and Civil Justice: A Survey of Americans: Major Findings from the Comprehensive Legal Needs Study, A.B.A. (1994), archived at <https://perma.cc/436W-HQYC>.

¹²⁶ See Greene, *supra* note 108, at 1289–90.

¹²⁷ See Leonard Wills, *Access to Justice: Mitigating the Justice Gap*, A.B.A. (Feb. 25, 2020), <https://www.americanbar.org/groups/litigation/committees/minority-trial-lawyer/practice/2017/access-to-justice-mitigating-justice-gap/>.

Pro bono and legal aid programs exist to provide services for low-income individuals in civil cases, but they must turn away many eligible people due to limited scope and resources.¹²⁸ Further, many low-income individuals, while unable to access legal services on their own, have incomes that are just high enough to render them ineligible for aid.¹²⁹ In 2019, individuals had to make less than \$16,100 annually to be eligible for aid from Legal Services Corporation (“LSC”), the “largest funder of civil legal aid” in the nation.¹³⁰ As indicated by Table 2 below, only a small percentage of individuals can take advantage of LSC services.

TABLE 2 – *Percentage of full-time wage and salary workers who would be ineligible for LSC services in 2019 by selected demographic characteristics [in thousands]*¹³¹

<i>Characteristic</i>	<i>Number of workers with annual average earnings of above \$18,200.00</i>	<i>Total Employed</i>	<i>Percentage</i>
White			
Men	49,919	51,110	97.67 %
Women	37,426	39,084	95.76%
Black or African American			
Men	7,089	7,378	96.08%
Women	7,560	8,081	93.55 %
Asian			
Men	4,239	4,334	97.81%
Women	3,448	3,563	96.77%
Hispanic or Latino ethnicity			
Men	12,160	12,611	96.42%
Women	8,021	8,616	93.09%

Although Black women had the second lowest percentage of earners to be considered as such, at least 94% of them were above low-income status in

¹²⁸ See *Frequently Asked Questions*, A.B.A. (Feb. 25, 2020), https://www.americanbar.org/groups/legal_services/flh-home/flh-faq/.

¹²⁹ See Buckwalter-Poza, *supra* note 120.

¹³⁰ See 45 C.F.R. § 1611.3(c)1 (2017); see also *Who We Are*, LEGAL SERVS. CORP., https://www.lsc.gov/about-lsc/who-we-are?gclid=CJwKCAjw092IBhAwEiwAxR11Rgn1nwc8FF68Qw7ES8dB37b1_sbU3H6C_GB90bw7boXaS4ND1OWiWRoCsJ0QAvD_BwE, archived at <https://perma.cc/ST48-ER3W>.

¹³¹ See U.S. BUREAU OF LAB. STAT., *supra* note 123, at 41. This table was derived from data in Table 6 by multiplying “usual weekly earnings” by fifty-two. Note that more individuals could have been ineligible for LSC services than are represented in Table 2, seeing that the U.S. Bureau of Labor Statistics data does not specifically account for incomes between \$16,100 and \$18,200.

2019, and therefore, could not take advantage of LSC services.¹³² Low-income cutoffs leave many ineligible for legal aid, yet unable to afford a private lawyer, rendering key legal resources inaccessible to Black women.¹³³

Women with low-incomes face an additional problem: they must give up their private information to state actors more often than higher-income women.¹³⁴ When individuals use Medicaid for prenatal care, they have to establish proof of identity, address, income, and pregnancy by providing an Expected Date of Confinement letter that establishes their projected delivery date based on their last menstrual cycle.¹³⁵ All of these requirements give way to a heavily-regulated relationship with the state and puts women's pregnant bodies under the surveillance of the state.¹³⁶ Low-income women have to give up private access to their lives in a way that those who can afford private insurance do not. As Black women are a demographic more likely to be low-income,¹³⁷ the government's subsidization becomes a "recruitment device" disproportionately converting Black low-income bodies into subjects of the state.¹³⁸ This may prove to be yet another obstacle for Black women who fall into low-income categories that deters the utilization of the U.S. healthcare system.

C. *Self-Sufficiency*

There is also a cultural dynamic of "self-sufficiency" for many Black women that lowers their likelihood to seek out a lawyer for assistance. The "superwoman complex" describes how Black women strive to be self-sufficient and cope with onerous societal expectations.¹³⁹ This complex results in them taking on an unrealistic amount of duties, such as manifesting strength, suppressing emotions, resisting being vulnerable or dependent, helping others, and succeeding despite limitations or lack of resources.¹⁴⁰ Research suggests Black women over forty-five years of age with some college education feel the strongest need to manifest strength.¹⁴¹ For Black women, it is necessary to present an image of strength in almost every arena of life without complaining for the sake of their children, parents, and friends.¹⁴² Some-

¹³² See *id.* (showing that 94% of Black women who participated in a Current Population Survey conducted by the U.S. Census Bureau had weekly earnings of \$350 or more).

¹³³ See Brian Libgober, *Getting a Lawyer While Black: A Field Experiment*, 24 LEWIS & CLARK L. REV. 53, 64 (2020).

¹³⁴ See KHLARA M. BRIDGES, REPRODUCING RACE 171 (2011).

¹³⁵ See *id.* at 167.

¹³⁶ See *id.* at 184.

¹³⁷ See Table 1.

¹³⁸ See BRIDGES, *supra* note 134, at 66.

¹³⁹ See *id.*

¹⁴⁰ See *id.*

¹⁴¹ *Id.*

¹⁴² *Id.*

times this coping mechanism serves as a source of pride for Black women, but other times it can cause them stress and health issues.¹⁴³

Why might a Black woman take on all of these burdens? To preserve herself, her community, and her family. If a Black woman fulfills the role of the “superwoman”—despite the obstacles and the lack of resources she endures in the workforce, romance, home, and society at large—she supports her family and facilitates her children’s growth into being better people with more opportunities. For example, by suppressing her emotions, she protects her employment and ability to provide for her family because she is less likely to be perceived as a problematic employee.¹⁴⁴ If a Black woman expresses negative emotions, that emotion is likely to be amplified because of the “Angry Black Woman” stereotype.¹⁴⁵ This stereotype distorts Black women’s emotional experiences by characterizing them as “aggressive, ill-tempered, illogical, overbearing, hostile and ignorant without provocation.”¹⁴⁶ Accordingly, Black women who express discontent or anger are more likely to be perceived as unacceptable.¹⁴⁷ For those women who need to protect their livelihoods, this impossible standard creates a fork in the road: authenticity or survival.¹⁴⁸ Most choose survival.¹⁴⁹

Thus, Black women have been forced to take on the roles of “mother, nurturer and breadwinner” for survival due to racism, intersectionality-based oppression, and disenfranchisement.¹⁵⁰ This dynamic is compounded by the mass incarceration of Black men that renders them largely unable to offer support.¹⁵¹ Even in the medical context, the “superwoman” complex means Black women are more likely to internalize and deal with all of their issues single-handedly.¹⁵² If a Black woman is injured, she may try home remedies and nurse the injury herself to keep up with the rest of her responsibilities

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ See Daphna Motro, Jonathan B. Evans, Aleksander P.J. Ellis, Lehman Benson III, *Race and Reactions to Women’s Expressions of Anger at Work: Examining the Effects of the “Angry Black Woman” Stereotype*, *J. APPL. PSYCHOL.* 1, 1 (2021), <https://pubmed.ncbi.nlm.nih.gov/33793257/>, archived at <https://perma.cc/A3VQ-J2SE>.

¹⁴⁶ See Wendy Ashley, *The Angry Black Woman: The Impact of Pejorative Stereotypes on Psychotherapy with Black Women*, *NAT’L INST. OF HEALTH* 27, 27–30 (2014).

¹⁴⁷ *See id.*

¹⁴⁸ *See id.*

¹⁴⁹ *See id.*

¹⁵⁰ See Cheryl L. Woods-Giscombé, *Superwoman Schema: African American Women’s Views on Stress, Strength, and Health*, *NAT’L INST. OF HEALTH* 1, 2 (2010), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3072704/>, archived at <https://perma.cc/W475-X9QR>.

¹⁵¹ See ALEXANDER, *supra* note 117, at 180 (analyzing the effects of mass incarceration on Black men including the lack of male presence to support their families); see also *Incarcerated Women and Girls*, THE SENTENCING PROJECT (Nov. 24, 2020), <https://www.sentencingproject.org/publications/incarcerated-women-and-girls/>, archived at <https://perma.cc/YC9S-ZG3S> (noting that while the rate of imprisonment for Black women has been declining since 2000, in 2019, the imprisonment rate for Black women was still over 1.7 times the rate of imprisonment for white women, yet another source of strain for Black families).

¹⁵² See Woods-Giscombé, *supra* note 150, at 7.

and to maintain the preservation of her family unit.¹⁵³ Seeking assistance from the civil legal system will, in her mind, display her private affairs and emotions in a public manner, which can be troublesome for Black women.¹⁵⁴ Some feel that even if they voiced concern, no one would understand what they were going through and that they might be mischaracterized as the “Angry Black Woman.”¹⁵⁵ Others do not know how to express their emotions or need for help.¹⁵⁶ Instead of publicly exposing herself during a trial, the predisposition of many Black women is to handle their issues privately and subsist through the “superwoman” complex.¹⁵⁷

Given this sociopolitical context, when a Black woman suffers injury due to medical bias, her instinct may be to rely on the self-sufficiency that has allowed her to cope with structural racism in the United States. She may doubt the ability of legal resources to adequately address her needs, even if she has a basic understanding of her legal rights. Unfortunately, pursuing litigation through the legal system is out of reach for many due to a lack of legal literacy, resources, and the burden of a cultural complex born from racial sins of the past and sustained by its vestiges. When these obstacles to legal resources are combined with persistent racism in the U.S. healthcare system, Black women’s path to legal redress is compromised, which negatively affects the efficacy of legal recourse to address their suffered harm.

Is there an appropriate remedy that can be offered for these profound harms? In light of Black women’s unique plight and habitual marginalization, there must be a clear framework moving forward that prioritizes their access to restoration.

IV. THE REMEDIES TO THE HARMS

Taking into account the different types of harms previously raised, it is hard to clearly distill solutions to help make Black women whole. No amount of money or restitution can replace a loved one who has suffered a preventable death. It is also impossible to place a price on irreversible physical injuries that would have been avoided but for bias. Because there are some injuries that simply cannot be repaired, it is necessary to examine preventative efforts.

A legal framework that signals bias as a threat to the entire health care system could go a long way towards avoiding these permanent injuries. In April of 2021, the House of Representatives introduced a bill that was referred to the House Committee on Energy and Commerce,¹⁵⁸ called the Maternal CARE Act, to “eliminate racial disparities in maternal health

¹⁵³ See *id.* at 13.

¹⁵⁴ See *id.* at 7.

¹⁵⁵ See Motro et al., *supra* note 145.

¹⁵⁶ See Woods-Giscombé, *supra* note 150, at 7.

¹⁵⁷ See *id.*

¹⁵⁸ Maternal CARE Act, H.R. 2556, 117th Cong. (2021).

outcomes,” which would help build such a legal framework.¹⁵⁹ The bill calls for funding programs to support implicit bias training with priority given to obstetrics and gynecology.¹⁶⁰ It also calls on the National Academy of Medicine to incorporate bias recognition into clinical skills testing.¹⁶¹ Finally, the bill calls for establishing statewide medical programs to provide more individualized maternal care inside of the safety of the new mother’s own home.¹⁶² These initiatives are aimed to support state governments in “end[ing] preventable morbidity” and better protecting mothers from experiencing harm during pregnancy. The bill is currently still being considered by the House Committee on Energy and Commerce’s subcommittee on health.¹⁶³

While this bill can help protect against the suffering of physical harms, no one solution to Black women’s circumscribed access to justice is infallible. If and when prevention efforts fail a patient, and injury occurs, the question of how an injured patient can be made whole rears its head again and remedy efforts advance to the forefront. There are two broad categories of remedies: non-judicial and judicial.¹⁶⁴ Typical types of non-judicial remedies are self-help remedies, administrative remedies, and alternative dispute mechanisms.¹⁶⁵ Among the judicial remedies are damages, restitution, and coercive remedies. For Black women, the accessibility of these remedies varies.

A. *Non-Judicial Remedies*

Non-judicial remedies, such as self-help remedies, administrative remedies, and alternative dispute mechanisms, are available to Black women.¹⁶⁶ Self-help remedies typically look outside of the legal process in order to resolve issues.¹⁶⁷ In relevant part, self-help remedies, such as grassroots education, can address historical trauma transferred through generations. An educational effort can start in local communities where agents of change could help educate Black women on the resources available to them in a way that does not patronize or gaslight them on their experiences. Such an experience would painstakingly undo emotional and psychological trauma at the local level. Additionally, an increase in legal literacy may lead to more patients holding their physicians accountable for decisions that may be overshadowed

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ *H.R.2556 – Maternal CARE Act*, CONGRESS.GOV, <https://www.congress.gov/bill/117th-congress/house-bill/2556/all-actions?r=2&overview=closed&s=1#tabs> (last visited Nov. 21, 2021).

¹⁶⁴ See Dobbs & Roberts, *supra* note 11, at 2–8.

¹⁶⁵ See *id.* at 8.

¹⁶⁶ See *id.*

¹⁶⁷ See *id.*

owed by implicit bias before an injury happens. Projects like the Black Mamas Matter Alliance and the National Birth Equity Collaborative engage in local educational efforts by creating toolkits, making recommendations to elected officials, and conducting responsive trainings with hospitals.¹⁶⁸ Such community engagement and education efforts may be able to successfully confront historical trauma.¹⁶⁹

In contrast, administrative remedies are provided by an administrative agency with jurisdiction over an issue. The Office for Civil Rights (“OCR”), for example, provides administrative remedies for civil and constitutional rights violations, given its jurisdiction over Title VI of the Civil Rights Act of 1964 (“Title VI”) and other acts of Congress.¹⁷⁰ It prohibits any program or activity that receives federal funding from discriminating by providing that “[n]o person in the United States shall, on the ground of race, color, or national origin . . . be subjected to discrimination under any program or activity receiving Federal financial assistance.”¹⁷¹ It further authorizes agencies that extend federal funding to promulgate regulations to effectuate the mandate,¹⁷² granting regulatory power to OCR to secure compliance of programs by leveraging federal funding.¹⁷³

The administrative relief process provided by the Civil Rights Act is initiated when a complaint is filed and an investigator collects information about the incident.¹⁷⁴ After the investigation, OCR issues a decision letter indicating whether there is a violation.¹⁷⁵ If there is a violation, the violating entity is given a period of time to correct the violation.¹⁷⁶ If the entity refuses to cooperate, OCR can recommend initiating enforcement proceedings, which may result in the termination of federal financial assistance.¹⁷⁷ The OCR can enforce the statute by either refusing to provide federal assistance or by “any other means authorized by law,” which typically has been a

¹⁶⁸ BLACK MAMAS MATTER ALLIANCE, <https://blackmamasmatter.org/resources/toolkits/>, archived at <https://perma.cc/6F6J-MJ9Z>; *What We Do*, NAT’L BIRTH EQUAL COLLABORATIVE, <https://birthequity.org/what-we-do/> archived at <https://perma.cc/A9R8-P3Ps>.

¹⁶⁹ See *Highlights*, GRASSROOTS L. PROJECT, <https://www.grassrootslaw.org/highlights>, archived at <https://perma.cc/99JF-ED3L> (detailing how grassroots efforts have changed policies and supported families that were torn apart by the continuous historical trauma of policing Black bodies).

¹⁷⁰ See *Office for Civil Rights*, U.S. DEP’T OF HEALTH & HUM. SERVICES, <https://www.hhs.gov/ocr/index.html>, archived at <https://perma.cc/594F-RBWL>.

¹⁷¹ *Id.*

¹⁷² Mary Crossley, *Infected Judgement: Legal Responses to Physician Bias*, 48 VILLANOVA L. REV. 196, 263–64 (2003).

¹⁷³ See Olatunde Johnson, *Lawyering That Has No Name: Title VI and the Meaning of Private Enforcement*, 66 STANFORD L. REV., 1293, 1297–98 (2014).

¹⁷⁴ *What to Expect*, U.S. DEP’T OF HEALTH & HUM. SERVICES, <https://www.hhs.gov/civil-rights/filing-a-complaint/what-to-expect/index.html>, archived at <https://perma.cc/KL4L-BG6A>.

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

lawsuit brought by the Attorney General seeking compliance with Title VI.¹⁷⁸

Obtaining compensatory damages using Title VI as an administrative remedy can prove to be difficult, as the requisite evidence for intentional discrimination is often hard to procure.¹⁷⁹ Accordingly, it is not ideal for addressing economic harms,¹⁸⁰ but it can result in corrective action which may help prevent future harm.

Finally, there are alternative dispute mechanisms, such as arbitration. Many medical malpractice suits end up in arbitration because the patient signed an agreement that waived her right to a jury trial and likely did so unaware that she was signing away her rights.¹⁸¹ But even if she did not sign such an agreement, a Black woman may choose to arbitrate. Lawsuits can incur “high emotional and financial costs,” whereas arbitration allows parties more control over the resolution process and gives them the ability to select the arbitrator.¹⁸² The arbitration process is typically less expensive, more private, and faster than litigation.¹⁸³ As such, it is an alternative legal tool for Black women who want to avoid the legal costs of a drawn-out lawsuit. The world of non-judicial remedies is flexible and, like judicial remedies, non-judicial remedies have their strengths and weaknesses in addressing particular harms.

B. Judicial Remedies

Damages, restitution, and coercive remedies are typical categories of judicial remedies that are available to Black women.¹⁸⁴ Each category can address certain types of harms depending on the case and what a court allows. In relevant part, judicial remedies have much to offer in terms of addressing the world of harms for a Black woman injured by medical bias.

Damages are a type of monetary remedy that aim to either compensate for past and anticipated future harms or deter undesirable behavior.¹⁸⁵ Compensation is useful for addressing economic harms because, unlike a life or limb, dollars are replaceable. So, in the event that a patient loses money paying for unnecessary procedures or in litigation, damages can return the patient to her economic state before the injury. Damages are also useful in

¹⁷⁸ Johnson, *supra* note 173, at 1298.

¹⁷⁹ See *Title VI Legal Manual*, U.S. DEP'T. OF JUST., <https://www.justice.gov/crt/fcs/T6Manual9> (last visited Jan. 11, 2022).

¹⁸⁰ *Id.*

¹⁸¹ See Andrew Suszek, *Using Arbitration for a Medical Malpractice Claim*, ALLLAW, <https://www.alllaw.com/articles/nolo/medical-malpractice/arbitration.html>, archived at <https://perma.cc/V47V-YVVQ>.

¹⁸² Ann Nevers, *Medical Malpractice Arbitration in the New Millennium: Much Ado About Nothing?*, 1 PEPP. DISP. RESOL. L. J. 45, 47–50 (2000).

¹⁸³ See *id.*

¹⁸⁴ See Dobbs & Roberts, *supra* note 11, at 3–6.

¹⁸⁵ See *id.* at 3–4.

detering undesirable behavior. If enough punitive damages are imposed upon practitioners who harbor bias, that behavior should ideally decrease. In this way, deterrence encourages practitioners to take a critical eye to their conscious and unconscious prejudices.

Several states set limits or caps on the amount of punitive damages available in medical malpractice cases, citing lower medical malpractice insurance premiums and the potential of increasing the pool of available physicians.¹⁸⁶ However, because attorneys may find that pursuing medical malpractice actions in jurisdictions that utilize a severe cap is not worth the effort, those punitive damage caps weaken a key deterrent for negligent behavior from racially biased physicians; as a result, injured patients are less likely to be able to hold biased physicians accountable.¹⁸⁷ Consequently, the caps provide another barrier to making Black women who have sustained injuries from medical racism whole. Where serious harm to vulnerable communities has occurred as a result of racism, effective punitive damage caps remain necessary. The application of consistent and reasonably substantial punitive damages can help address generational harm by rebuilding trust and showing a commitment to correcting dangerous behaviors.

Another remedy, restitution, aims to restore and prevent unjust enrichment.¹⁸⁸ Sometimes this may mean compensation, but at other times, it could mean a return of a literal object taken from the patient.¹⁸⁹ Whereas damages are measured by the patient's loss, restitution is measured by the physician's gain, which is especially important in cases where the defendant's gain exceeds the patient's loss as a result of the injury.¹⁹⁰ Restitution typically aims to restore a singular victim, but the collective use of restitution can go toward addressing generational harms. For example, it is clear that the U.S. medical field has made extraordinary gains on the backs of Black women and the Black community as a whole.¹⁹¹ Meanwhile, the Black community continues to experience the negative effects of this unjust enrichment, losing limbs and lives, as well as overall trust in the medical system.¹⁹² The U.S. medical community's excessive educational gains constitute unjust enrichment and can be addressed through restitution.

One potential initiative that can work toward proper restitution of the Black community's access to proper health care is the creation of a law

¹⁸⁶ See Leonard J. Nelson III, Michael A. Morrissey, & Meredith L. Kilgore, *Damages Caps in Medical Malpractice Cases*, 85 MILBANK Q. 259, 281 (2007).

¹⁸⁷ See Katherine Hubbard, *Breaking the Myths: Pain and Suffering Damage Caps*, 64 ST. LOUIS U. L. J. 289, 307 (2002) (noting how victims of Christopher Duntsch's ("Dr. Death") deadly malpractice found it difficult to find an attorney who would take their cases because the punitive damage caps in Texas made the cases not worth their time and energy).

¹⁸⁸ See *id.* at 4–5.

¹⁸⁹ *Id.* at 4.

¹⁹⁰ See *id.*

¹⁹¹ See Owens, *supra* note 16, at 21; see also Hoffman et al., *supra* note 12.

¹⁹² See The Exchange, *supra* note 22.

based on restitution or reparation, both of which have roots in restoration.¹⁹³ Recently, the House advanced a slavery reparations bill,¹⁹⁴ designed to address the structural racism experienced by Black people in the United States. Still, there is a question of whether the unjust enrichment of the U.S. medical system is separable from the unjust enrichment of the United States as a whole. If the bill becomes a law, the medical transgressions of the United States against Black people may be incorporated as a part of the structural racism facing Black people throughout U.S. history.

Another form of judicial remedy takes the form of coercive remedies, such as injunctions or orders of specific performance. These are demands by courts for a defendant to do or refrain from doing something.¹⁹⁵ Those who disobey these orders can be jailed, fined, or sanctioned.¹⁹⁶ In contrast with earlier mentioned remedies, coercive remedies are enforceable against the actual person, as opposed to being enforceable against the person's property.¹⁹⁷ Consistent and effective coercive remedies may be able to address generational harms because they signal to injured parties that the system is taking their health seriously. Affirmation of patient value is helpful to confront emotional harms resulting from lackluster care and poor attention to Black women's concerns, such as the fear of going to a physician's office.¹⁹⁸ Coercive remedies can also speak to prevention: should a practitioner be enjoined from practicing due to dangerous conduct, the next patient might be spared a horrible injury. For example, Christopher Duntch, nicknamed "Dr. Death," committed many medical errors resulting in deaths and devastating injuries to patients before his medical license was suspended and fully revoked in December 2013.¹⁹⁹ The revocation of his license has prevented other patients from suffering from his serial malpractice.

Judicial remedies are often unattainable because Black women can only access these remedies if they successfully prove their case through legal recourse. Due to pervasive bias and obstacles such as income barriers or ingrained survival techniques, judicial remedies are often an idea instead of a reality. While this overview might seem bleak, legal recourse, designed to make these remedies for particular harms accessible, does exist. However, it is important to take note of the accessibility and efficacy of recourse availa-

¹⁹³ See generally Kathleen Daly & Gitana Scifoni, *Reparation and Restoration*, OXFORD HANDBOOK CRIME CRIMINAL JUSTICE 1, 1 (Mar. 3, 2010), https://www.researchgate.net/publication/228601243_Reparation_and_Restoration, archived at <https://perma.cc/S9SS-XFNH>.

¹⁹⁴ H.R. 40, 117th Cong. (2021).

¹⁹⁵ Remedy, AM. L. LEGAL INFO., <https://law.jrank.org/pages/9760/Remedy.html>, archived at <https://perma.cc/7AEV-3CDA> (last visited Apr. 22, 2021).

¹⁹⁶ Dobbs & Roberts, *supra* note 11, at 5.

¹⁹⁷ *Id.*

¹⁹⁸ See Anwar, *supra* note 69.

¹⁹⁹ Hubbard, *supra* note 188, at 306; see also Mahita Gajanan, *Peacock's Dr. Death Is Based on a Chilling True Crime Podcast About a Murderous Surgeon*, TIME (Jul. 16, 2021), <https://time.com/6080714/dr-death-true-story/>.

ble to Black women in remedying their emotional, physical, and economic harms.

V. LEGAL RECOURSES FOR BLACK WOMEN

Remedy is the goal, whether non-judicial or judicial in nature. Remedies are the judicial treatment to a legal injury.²⁰⁰ The application of relief through remedy, however, is not automatic, and is instead a right that must be exercised.²⁰¹ In order to exercise these rights, and determine the nature and scope of relief to be awarded, Black women must prove their case through legal recourse.²⁰² Thus, legal recourse is the vehicle that transports its passengers to the goal of remedy. Each recourse has its advantages and consequences that affect its efficacy. Unfortunately for Black women, many of these vehicles have major flaws. They lack a function that comprehensively deters racial discrimination and allows access to information proving that a physician discriminated against the patient. This ultimately renders what should be a quality vehicle for relief into a mere prototype incapable of satisfaction. There are different types of avenues of recourse for Black women facing poor health outcomes due to medical bias, including medical malpractice cases and lawsuits arising under Title VI of the Civil Rights Act of 1964. The following sections provide an overview of these avenues and their potential for efficacy.

A. Medical Malpractice

One avenue of legal recourse for Black women after sustaining an injury is a medical malpractice action. In such an action, the plaintiff alleges that the medical care she received failed to conform to the standard level of care and that this failure led to her injury.²⁰³ This type of action typically requires expert testimony to demonstrate that the physician's actions were inconsistent with the customary standard.²⁰⁴ The plaintiff has to make a sufficient *prima facie* claim for a medical malpractice suit by proving the traditional elements of tort liability: duty, breach, causation, and injury. The element most critical to our current analysis is breach.²⁰⁵

To prove breach, the plaintiff must first show how physicians in the same or similar circumstances as the treating physician customarily practice, and second, how the treating physician departed from that practice.²⁰⁶ It is important to note that custom typically controls here. This essentially means

²⁰⁰ See generally Dobbs & Roberts, *supra* note 11, at 1–3.

²⁰¹ See *id.*

²⁰² See *id.* at 1–2.

²⁰³ Crossley, *supra* note 172, at 244.

²⁰⁴ *Id.*

²⁰⁵ See *id.*

²⁰⁶ See *id.*

that the medical profession can establish its own standard of care.²⁰⁷ If bias is not something Black women often encounter at the physician's office, then custom should be a safeguard that protects them from physicians that harbor bias. Against this standard, a biased physician would be held accountable for departing from the customary practice of being unbiased. However, because bias is typically normalized into medical custom, this framework does not expose it. Given the dismal statistics on Black experiences within the U.S. medical system, safeguards against bias, to the extent that they exist, are evidently not effective.²⁰⁸ This presents a problem because while "[n]egligence cannot be excused on the grounds that others practice the same kind of negligence,"²⁰⁹ in reality, the negligence that causes Black women medical injury often tends to go unnoticed. Further, when medical bias rooted in racism becomes the standard, it becomes harder for Black women to plead enough of a factual allegation that rises above speculation,²¹⁰ ultimately harming the efficacy of their action.

While local custom is the traditional rule, it is not the only rule. A trend has emerged evincing a shift away from the custom-based standard of care to the broader reasonable physician standard of care.²¹¹ Under a reasonable physician standard, a physician can breach their duty even though they adhered to customary, but harmful, practices if those practices were not objectively reasonable.²¹² This would improve Black women's ability to successfully prove this element.

Another barrier in pursuing this cause of action is the additional expense of expert testimony. Expert testimony, which is used to demonstrate customary practices, is essential to demonstrate breach. For background, plaintiffs and defendants bring in other physicians or "experts" and use their testimony to explain what is customary in their practice. Experts are usually subject to rules governing what they are able to testify regarding the standard of care, such as the same or similar locality rule or the national rule.²¹³ While employing experts may be necessary for judges and juries to understand very specialized and niche issues, it is important to recognize that this

²⁰⁷ See Richard N. Pearson, *The Role of Custom in Medical Malpractice Cases*, 51 *INDIANA L. J.* 528, 544 (1976).

²⁰⁸ See *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 7, 2017), <https://www.npr.org/2017/12/07/568948782/Black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why>, archived at <https://perma.cc/NTH9-2Y7X>.

²⁰⁹ *Vassos v. Roussalis*, 625 P.2d 768, 772 (Wyo. 1983).

²¹⁰ See *Liggon-Redding*, No. 14-3139 at *2; see generally *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (explaining that a pleading must rise above mere speculation).

²¹¹ See Robert Simon, *Standard-of-Care Testimony: Best Practices or Reasonable Care?*, 33 *J. AM. ACAD. PSYCHIATRY L.* 8, 8 (2005).

²¹² *Id.*

²¹³ *Id.*

practice provides an extra hurdle for Black women who cannot afford the extra expense.²¹⁴

i. Efficacy of Medical Malpractice in Addressing Harms

Medical malpractice damages can be effective in addressing economic harms but may fall short in addressing emotional and psychological harms because they do not directly address the cause of the injury: the bias. Without discouraging racial bias, the root of the issue continues to threaten the dignity of Black women as patients. Indeed, in a medical malpractice action, bias is not at issue. Unless the substandard treatment due to racial bias falls outside of the standard of care, the treatment decision will not be grounds for a successful malpractice action.²¹⁵ If the patient were to win the action, then she would recover for negligence, not biased treatment. Thus, there is no legal deterrent for the underlying biased behavior. Besides a rote reprieve for negligence, the racial and gender bias goes largely unpunished, which fails to stop the generational, emotional, and psychological harm that this racial bias perpetuates.

B. Informed Consent: A Type of Medical Malpractice Action

Because medicine can be so specialized, patients may not know what they need or how to evaluate the quality of medical care they receive.²¹⁶ Patients are entitled to make their own decisions about their medical care, but they usually do not have the specialized medical training to understand the significance and implications of treatments or other diagnoses.²¹⁷ This information deficit can be life threatening, but can be remedied by an informed consent requirement.²¹⁸ Informed consent, as a type of medical malpractice action, aims to reduce the disadvantages of asymmetrical information between the patient and the physician as the patient's agent, and is another avenue of redress for Black women who have been injured due to medical bias.²¹⁹ Informed consent requires physicians to disclose to patients the risks, benefits, and alternatives of a procedure that an average patient would find material to their decision of whether to proceed.²²⁰ A general consent form is insufficient because it amounts to *mere* consent instead of

²¹⁴ *Id.* On average, an expert witness' up-front retainer can reach up to \$15,000. The hourly rate for in-court expert testimony ranges from \$75 to \$7,500, and hourly rate for depositions can reach up to \$3,000. *Expert Witness Fees*, SEAK Inc., <https://seak.com/expert-witness-fee-study/>, archived at <https://perma.cc/ZB2Z-HMDM>.

²¹⁵ See *What is Medical Malpractice?*, AM. BOARD OF PROF. LIABILITY ATT'YS., <https://www.abpla.org/what-is-malpractice>, archived at <https://perma.cc/B45E-UWAM>.

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ *Id.*

²¹⁹ *Id.*

²²⁰ *Id.*

informed consent.²²¹ Additionally, as part of achieving informed consent, physicians must disclose personal interests that may affect their professional judgment, such as a financial interest in any treatment.²²² Because this action is a type of medical malpractice action, the patient still has to prove the traditional elements of tort liability: duty, breach, causation, and injury.²²³

Duty and Breach

The duty element of informed consent requires that the physician inform the patient as to the nature of care, the purpose of care, and disclose any non-remote risks associated with the treatment.²²⁴ For the breach element of the claim, some jurisdictions use a malpractice standard to decide whether a warning of such risk aligns with the customary standard of care.²²⁵ This means that if a patient is in that jurisdiction, she will have to overcome the complications of establishing what is customary for a medical malpractice claim.²²⁶ Other jurisdictions use a material risk standard, in which physicians have an overall duty to inform the patient of those risks that a reasonable patient would find material in their position.²²⁷ In most cases, breach is not due to a total disregard for informed consent; the issue is more so inadequate disclosure or that the physician did not discuss other alternative treatments or diagnostic options.²²⁸

Causation and Injury

Finally, it is important to note that a patient cannot recover simply by showing a negligent failure to disclose alternatives.²²⁹ She must also show that the failure to disclose alternatives caused her harm.²³⁰ She must establish that if adequate disclosure existed, she would have opted for another course of action and therefore avoided injury.

i. Efficacy of Informed Consent in Addressing the Harms

The physician's duty to disclose brings up another glaring issue particular to the Black community: lack of trust for the medical profession. En-

²²¹ See *Rizzo v. Schiller*, 248 Va. 155, 156 (Va. 1994). "The law requires informed consent, not mere consent, and the failure to obtain informed consent is tantamount to no consent." See *id.* at 156. In this case, a physician used forceps while the patient was in labor, resulting in brain damage to the patient's baby. At the time of the case, forceps were known by physicians to produce brain injuries in fetuses, but this was not disclosed to the patient and the patient did not have an opportunity to evaluate the risk for herself. Although the patient had signed a general consent form, the court found that the form was insufficient in fulfilling the physician's duty to inform the patient about the risks.

²²² See *Moore v. Regents of Univ. of Cal.*, 51 Cal.3d 120, 121 (Cal. 1990).

²²³ See *id.*

²²⁴ See Crossley, *supra* note 172, at 248.

²²⁵ See Edward L. Raab, *The Parameters of Informed Consent*, 102 TRANSACTIONS AM. OPHTHALMOLOGICAL SOC'Y., 225, 226 (2004).

²²⁶ *Id.*

²²⁷ See *Canterbury v. Spence*, 464 F.2d 772, 786 (D.C. Cir. 1972).

²²⁸ See generally Crossley, *supra* note 173, at 248.

²²⁹ *Id.* at 249.

²³⁰ *Id.*

democratic distrust for the medical profession may affect the efficacy of informed consent. There is a growing body of evidence showing that minorities are misinformed when it comes to medical research and that there are cultural and contextual issues that influence minorities' reactions to informed consent.²³¹ As a result of the abuse Black people have suffered from the U.S. healthcare system,²³² they are more likely to believe that they will be used as guinea pigs and are less likely to trust that medical research or healthcare options will be explained to them in their entirety.²³³

In a study by Professor Molly Altman, Black women's experiences during birth were influenced by how physicians "packaged" the information they disclosed to patients.²³⁴ A physician "packages" information when they provide partial or misleading information to make what the physician believes to be the best decision for the patient.²³⁵ The amount of information physicians choose to share depends on whether physicians see the individual as capable of making good decisions.²³⁶ In this way, the physician's control over the dissemination of information contributes to a power dynamic that leaves Black women with a diminished ability to maintain personal autonomy and make decisions for themselves and for those that depend on them.²³⁷

Informed consent actions get to the heart of negligence and can hold the physician directly accountable for their mistakes,²³⁸ but like medical malpractice, they do not typically send the message that the physician's racial bias was morally reprehensible. Informed consent may be able to address the economic harm of going through costly medical procedures that a Black

²³¹ See generally Sandra C. Quinn et. al., *Improving Informed Consent with Minority Participants: Results from Researcher and Community Surveys*, 7 J. OF EMPIRICAL RSCH. ON HUM. RSCH. ETHICS 44, 45 (2012); see also Giselle Corbie-Smith et. al., *Attitudes and Beliefs of African Americans Toward Participation in Medical Research*, 14 J. GEN. INTERNAL MED. 537, 537–46 (2002); see also Vicki S. Freimuth et. al., *African American's Views on Research and the Tuskegee Syphilis Study*, 52 SOC. SCI. & MED. 797, 797–808 (2001). But see April Dembosky, *Stop Blaming Tuskegee, Critics Say. It's Not an 'Excuse' for Current Medical Racism*, NPR (Mar. 23, 2021), <https://www.npr.org/sections/health-shots/2021/03/23/974059870/stop-blaming-tuskegee-critics-say-its-not-an-excuse-for-current-medical-racism>, archived at <https://perma.cc/SEHJ-EARN> (arguing that African Americans' distrust for the medical profession as it is attributed to the Tuskegee experiments may be overexaggerated).

²³² See Hoffman et al., *supra* note 12, at 4296.

²³³ See *id.*; see also Corbie-Smith et. al., *supra* note 232, at 539–40, 542; see also Freimuth et. al., *supra* note 232, at 797–98.

²³⁴ Molly R. Altman et. al., *Information and Power: Women of Color's Experiences Interacting with Healthcare Providers in Pregnancy and Birth*, 238 SOC. SCI. & MED. 1, 5 (2019) ("Information was often presented in such a way that decreased the women's abilities to be involved and actively participate in health care decisions."); see also Jake Ellison, *Pregnant Women of Color Experience Disempowerment by Healthcare Providers*, UNIV. OF WASH. NEWS (Feb. 2, 2020), <https://www.washington.edu/news/2019/08/27/pregnant-women-of-color-experience-disempowerment-by-health-care-providers/>, archived at <https://perma.cc/GU2G-ZVR2>.

²³⁵ See Altman et al., *supra* note 234.

²³⁶ See *id.*

²³⁷ See *id.*

²³⁸ See *id.*

woman would have elected against had they been properly informed. However, it is inadequate to appropriately address the emotional and psychological harm of the deepened distrust for the medical profession and the embarrassment caused by being at the mercy of a professional who has the power to decide if one is able to retain their personal autonomy. Without the proper acknowledgement of underlying bias, there is no deterrent for bad actors to stop biased treatment. The cycle of harm continues. The mighty endeavor of the legal system to make whole those who submit to its jurisdiction is reduced to a mere illusory promise. In this way, redress by way of informed consent, like medical malpractice, is insufficient and ends up being one-dimensional in rectifying harm.

C. Vicarious Liability

Black women are also able to hold healthcare institutions liable through vicarious liability. This is a theory of liability that holds a person or entity liable for the fault of another.²³⁹ Suing a hospital under a theory of vicarious liability can be difficult, given the United States' unique approach to healthcare. While many physicians are paid a salary at a hospital, more physicians are a part of a managed care system,²⁴⁰ through which organizations that take care of the patient's bill, such as insurance agencies, take an active role in managing the patient's care.²⁴¹ As a result of this system, it may be the case that the physician who sees the patient is not legally considered an employee of the hospital, but is instead an independent contractor.²⁴² If an injured Black woman tries to sue a hospital for the acts of a physician she thinks is an employee, but who in reality is an independent contractor, her claim could fail since employers typically do not retain control over independent contractors.²⁴³

However, the injured patient may still be able to argue for vicarious liability based on agency.²⁴⁴ If a physician who is an independent contractor has apparent authority over staff, the physician can be held liable.²⁴⁵ The independent contractor has apparent authority if the hospital holds out the

²³⁹ See Russell G. Thornton, *Responsibility for the Acts of Others*, 23 BAYLOR U. MED. CTR. PROC. 313, 313 (2010).

²⁴⁰ See Thomas P. Conklin, *Healthcare in the United States: An Evolving System*, 7 MICH. FAM. REV. 5 (2002), <https://quod.lib.umich.edu/m/mfr/4919087.0007.102?view=text;rgn=main>, archived at <https://perma.cc/CUH8-64JS>.

²⁴¹ See *id.*

²⁴² See Jennifer Arlen & W. Bentley MacLeod, *Torts, Expertise, and Authority: Liability of Physicians and Managed Care Organizations*, 36 RAND J. OF ECON. 494, 495 (2005).

²⁴³ *Id.*

²⁴⁴ See e.g., *Baptist Mem'l Hosp. v. Sampson*, 969 S.W.2d 945, 945 (Tex. 1998) (detailing how the claimant sued the physician for a negligent medical diagnosis and sued Baptist Memorial Hospital system under a theory of vicarious liability, but was ultimately unsuccessful at proving agency theory).

²⁴⁵ *Diggs v. Novant Health, Inc.*, 177 S.E.2d 851, 860 (N.C. Ct. App. 2006).

physician as its agent, the patient relies on that representation, and the patient's detrimental reliance results in harm.²⁴⁶

An action based on vicarious liability would help make the patient whole and send a message to hospitals to keep a closer eye on who they hire. Hospitals have deep financial pockets from which to gain restitution, and therefore can be sued for a significant sum of money. Thus, it may encourage hospitals to filter out physicians that could harm a vulnerable minority population, preventing future harm.²⁴⁷

D. *Title VI of the Civil Rights Act of 1964*

The Civil Rights Act of 1964 addresses discrimination in employment, voting, education, and public accommodations.²⁴⁸ As discussed earlier, an important mechanism in the Act is Title VI, which prohibits programs that receive federal funding from discriminating on the basis of race, color, or national origin.²⁴⁹ Title VI can be enforced administratively through the OCR.²⁵⁰ Title VI also provides access to remedies for private individuals upon a showing of intentional discrimination.²⁵¹ Intentional discrimination under this statute can be proven through a variety of ways, two of which are direct evidence and circumstantial evidence.²⁵² A policy that expressly treats individuals differently based on race is an example of direct evidence.²⁵³ Discrimination can be proven indirectly, by pointing to circumstantial evidence that a discriminatory purpose was more likely than not responsible for the mistreatment.²⁵⁴ Most cases today utilize circumstantial evidence, as finding direct evidence can be difficult.²⁵⁵

i. *Efficacy of Title VI of the Civil Rights Act of 1964 in Addressing Harms*

A Black woman who believes that her race influenced her physician's recommendation of medical treatment can seek monetary damages through Title VI if she can prove that a federally funded entity intentionally discriminated against her.²⁵⁶ There are many potential pitfalls to using this avenue for redress.

²⁴⁶ See *id.* at 859–60.

²⁴⁷ See generally PAULA GILIKER, VICARIOUS LIABILITY IN TORT: A COMPARATIVE PERSPECTIVE, 1 (Cambridge Univ. Press, 2013).

²⁴⁸ 42 U.S.C. § 2000(d) (2001).

²⁴⁹ *Id.*

²⁵⁰ See *Office for Civil Rights*, *supra* note 170.

²⁵¹ See *Title VI Legal Manual*, *supra* note 180.

²⁵² *Id.*

²⁵³ *Id.*

²⁵⁴ *Id.*

²⁵⁵ See *id.*; see also JARED P. COLE, CONG. RSCH. SERV., R45665, CIVIL RIGHTS AT SCHOOL: AGENCY ENFORCEMENT OF TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 6–7 (2019).

²⁵⁶ See Crossley, *supra* note 172, at 264.

1. Federal Funding Requirement

Title VI only applies to programs that receive federal funding. An entity can receive federal financial assistance through initiatives like Medicare, Medicaid, hospital construction grants, and community health clinic support.²⁵⁷ A “program or activity” may be a corporation, partnership, or even a sole proprietorship that is principally engaged in the business of providing healthcare.²⁵⁸ Most physicians receive federal money, but some physicians do not.²⁵⁹ These physicians would fall outside of the scope of Title VI.²⁶⁰

2. Gender Limitations

While Title VI prohibits racial and ethnic discrimination, it does not prohibit biased medical decisions based on gender. Black women face an issue of intersectionality.²⁶¹ Whereas a discriminatory issue that is applicable to Black people in general can be remedied under Title VI, a medical discriminatory issue unique to Black women can only be addressed under this statute through the lens of race. This becomes an issue when the class of potential victims are Black, but Black women are treated differently than Black men. For example, sickle cell disease (“SCD”) is an inherited blood disorder that causes the production of abnormal hemoglobin.²⁶² The CDC conducted a screening investigating the incidence of sickle cell in infants across thirteen states in 2010, finding that while there were three cases per 1,000 white newborns, for Black newborns there were 73.1 cases per 1,000.²⁶³

Assume that a Black woman wants to bring a case about how she was discriminated against in SCD treatment. If she found enough white women with whom to compare her treatment, Title VI may be a viable legal option. However, statistics show SCD is an issue that predominantly affects Black people.²⁶⁴ As a result, it is unlikely that enough white people with SCD are accessible to make this case. There are other conditions that affect Black people more often and severely that present a similar issue, such as diabetes,

²⁵⁷ See *id.*

²⁵⁸ 42 U.S.C. § 2000d-4a(3)(A)(ii) (2001).

²⁵⁹ See Crossley, *supra* note 172, at 265.

²⁶⁰ See *id.*

²⁶¹ See *id.* at 269.

²⁶² See *Sickle Cell Trait*, AM. SOC'Y OF HEMATOLOGY, <https://www.hematology.org/education/patients/anemia/sickle-cell-trait>, archived at <https://perma.cc/N4GP-EUNQ>; see also *Incidence of Sickle Cell Trait in the US*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/ncbddd/sicklecell/features/keyfinding-trait.html>, archived at <https://perma.cc/6BH7-A3ZC> (explaining that the trait that causes SCD is a defective gene that can be passed from generation to generation). If a child is born with only one defective gene, it is not life threatening. However, people with SCD receive two traits, a defective gene from each parent. See generally *Sickle Cell Disease*, MEDLINEPLUS, <https://medlineplus.gov/sicklecelldisease.html>, archived at <https://perma.cc/Y3T7-2YWC>.

²⁶³ See *Incidence of Sickle Cell Trait in the US*, *supra* note 263.

²⁶⁴ See *id.*

which is 60% more common in Black people,²⁶⁵ and death from lung sarcoidosis which is 61% more common in Black people.²⁶⁶ So, if a Black woman is trying to show that she was discriminated against in the treatment of her SCD, diabetes, or lung sarcoidosis by being treated differently than her Black male counterparts, it is likely that Title VI would not be helpful because there is no gender element.

3. *Proving the Physician Intentionally Discriminated*

To prove that a physician intentionally discriminated in their treatment, the patient can use direct and circumstantial evidence of discrimination.²⁶⁷ For example, imagine that a Black woman hurts her arm. When she goes to the hospital, the physician decides that she needs surgery, despite the custom being to use a non-invasive approach like physical therapy first. If she wants to use direct evidence to sue under Title VI because the physician ordered unnecessary surgery based on racial discrimination, she would need to show that her race was an explicit factor that the physician considered and weighed in their analysis. It is difficult for a patient to obtain direct causal evidence like this, as it often does not exist.²⁶⁸

Alternatively, a patient could use circumstantial evidence. Examples of such evidence include showing that when similarly situated white patients came in with the same injury, they were prescribed an adequate amount of opioids, or when other Black patients came in for pain relief they were also denied pain relief. She could also seek statistical proof, statements, or actions from the physician that show evidence of racial bias or discriminatory motive. While circumstantial evidence is more attainable than direct evidence, juries perceive it to be weaker, so it still may not be enough to support an assertion of a Title VI violation.²⁶⁹ In order to prevail, the patient has to prove that a discriminatory purpose is more likely than not the cause of the differential treatment.²⁷⁰

A clear benefit from a Title VI action is that it directly sends a message that admonishes racial bias, which was lacking in the medical malpractice actions discussed earlier. Indeed, one of the purposes of the Act is to address issues of disparate racial treatment. If the patient can (1) establish that the healthcare program or activity receives federal funding and (2) find the req-

²⁶⁵ See *Diabetes and African Americans*, U.S. DEP'T OF HEALTH AND HUM. SERVICES OFF. OF MINORITY HEALTH, <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18>, archived at <https://perma.cc/E8Z5-A6X3>.

²⁶⁶ See Mehdi Mirsaedi et. al., *Racial Difference in Sarcoidosis Mortality in the United States*, 147 CHEST 438, 440 (2015).

²⁶⁷ See COLE, *supra* note 255, at 6.

²⁶⁸ Cf. *id.* at 6–7.

²⁶⁹ See Kevin J. Heller, *The Cognitive Psychology of Circumstantial Evidence*, 105 MICH. L. REV. 241, 241 (2006). *But see id.* at 244 (noting that some scholars argue circumstantial evidence can be stronger than direct evidence).

²⁷⁰ See COLE, *supra* note 255, at 9.

uisite evidence for intentional discrimination, then a Title VI action would be viable for obtaining recourse.

Though the goal of Title VI is to incentivize the compliance of those federal institutions that receive federal support,²⁷¹ the right to recover individually under this part of the 1964 Civil Rights Act has been judicially limited through cases like *Alexander v. Sandoval*²⁷² and *Guardians v. Civil Service Comm'n of New York*.²⁷³ In both cases, the Supreme Court limited compensatory awards to cases in which the patient can prove intentional discrimination.²⁷⁴ Because it is quite difficult to obtain evidence of a clear intention to discriminate, this holding excludes a large number of those whom the act meant to protect.²⁷⁵ Whereas actions arising out of medical malpractice or informed consent are arguably easier to support with discoverable evidence, and thereby able to more readily address economic harms through damages, individual actions under Title VI are not as well-suited to respond to Black women's harms because intentional discrimination is hard to prove. If she cannot prove her Title VI case, then she cannot enjoy any remedy, which renders the recourse useless.

Reviewing the efficacy of these medical malpractice and Title VI recourses is necessary to start clearing the debris from a cluttered path of purported redress that is just out of reach for many of those who need it. By disposing of this clutter one piece at a time we can start developing a clearer path to legal redress for Black women.

E. A Clearer Path to Legal Redress

As previously discussed, income barriers and ingrained survival techniques are two examples of obstacles that obstruct the path to legal recourse and remedy thereafter. However, even when they are able to utilize legal recourses, Black women still lack two crucial assets to successfully achieve a remedy: (1) a practical way to punish racial bias and (2) access to information capable of proving that a physician discriminated against the patient. If the discrimination cannot be proven, then the racial bias goes unpunished, and the harm it causes is perpetuated. Although the information needed to prove intentional discrimination is generally rendered inaccessible by Health Insurance Portability and Accountability Act (HIPAA) laws, expanding when and how de-identified personal health information can be disclosed could provide a clearer path to legal redress for Black women.

²⁷¹ See Daniel Solomon, *Constraints on Damage Claims Under Title VI of the Civil Rights Act*, 3 MINN. J.L. & INEQUITY 183, 185 (1985).

²⁷² 463 U.S. 582 (1983).

²⁷³ 532 U.S. 271 (2001).

²⁷⁴ See Solomon, *supra* note 271.

²⁷⁵ See *id.*

A. *Implications of the Health Insurance Portability and Accountability Act (HIPAA)*

HIPAA laws “protect sensitive patient health information from being disclosed without the patient’s consent or knowledge.”²⁷⁶ Within HIPAA, the Privacy Rule addresses “the use and disclosure of individuals’ health information by entities subject to [it].”²⁷⁷ The HIPAA Privacy Rule encompasses exceptions to the prohibition on disclosing sensitive patient health information if the information is shared as a “Limited Data Set.”²⁷⁸ Limited Data Sets may be used or disclosed only for purposes of research, public health, or health care operations and only after sixteen identifiers have been removed for identity protection.²⁷⁹ It is because of this exception for research that we know that bias in the medical profession exists at all. For example, an implicit preference for white patients was found in nine separate studies in 2012.²⁸⁰ Further, two of those studies found an observable association of clinical decision-making associated with that bias.²⁸¹

Although we know that bias exists, it is still hard to prove in a court of law. Notably, proving discrimination in court is key to being able to redress the harm. Section 164.512(e) of the HIPAA Privacy Rule describes when disclosures of protected patient information in judicial and administrative proceedings is permitted without authorization from the patient.²⁸² Typically, a covered entity, like a hospital, is permitted but not required to disclose protected health information (“PHI”) if notice is given to the patient who is the subject of the PHI or if the parties agree to a qualified protective order that “prohibits the parties from using or disclosing the protected health information for any purpose other than the litigation or proceeding for which such information was requested” and must be returned after the proceeding concludes.²⁸³

Depending on the size of the data set, it may be an unreasonable burden to ask physicians to give notice to every potential subject of the data set and then make injured patients wait for the time for objections to pass, especially

²⁷⁶ See *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/php/publications/topic/hipaa.html#:~:text=the%20Health%20Insurance%20Portability%20and,the%20patient's%20consent%20or%20knowledge,archived%20at%20https://perma.cc/JS5Y-GZSG>.

²⁷⁷ *Id.*

²⁷⁸ 45 C.F.R. § 164.514(e)1–4 (2000).

²⁷⁹ 45 C.F.R. § 164.514(e)2 (2000) (including as identifiers names, postal address information, telephone numbers, fax numbers, electronic mail addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, certificate/license numbers, vehicle identifiers, device identifiers, URLs, IP address numbers, biometric identifiers, and full-face photographic images).

²⁸⁰ See Erin Dehon et. al., *A Systematic Review of the Impact of Physician Implicit Racial Bias on Clinical Decision Making*, 24 *ACAD. EMERGENCY MED.* 895, 895 (2017).

²⁸¹ *See id.*

²⁸² 45 C.F.R. § 164.512(e) (2000).

²⁸³ *Id.*

if the data set has been cleansed of identifiers. The extra time spent waiting and accruing legal expenses disproportionately burdens low-income Black women.²⁸⁴ Similarly, seeking a qualified protective order is another extra step that costs precious time.

B. Medical Bias Accountability Initiative: A Proposed Solution

One legislative action that could clear the path to legal redress and restitution for Black women injured by medical bias would be to isolate situations concerning medical bias against the Black community. For example, an initiative focused on medical accountability for bias could require the upkeep of records regarding the medical institution's treatment of Black people and the disclosure of de-identified PHI.²⁸⁵ Given the difficulty in proving disparate treatment, a hospital or medical center's history of treatment of Black women in comparison to their majority counterparts should be well-documented so that if an injury occurs, the injured party or an agent on their behalf can access a reliable record in a cost-effective way. Disclosure of this information would be without authorization from patients, and it automatically integrates a qualified protective order for the limited purpose of determining whether a patient's injury was due to racial bias in the healthcare system. A requirement here is necessary as the current rule only gives practitioners the option to disclose information and many opt not to disclose information due to confusion about the law.²⁸⁶ This sort of policy would be a step toward change, honoring the dignity of Black women as patients and alleviating the emotional and psychological pain of being overlooked by the medical system.

An act that provides a clearer avenue to legal recourse for medical racism is necessary in a country where Black people are in such a vulnerable position. This policy change would specifically address racial bias, give marginalized populations a better chance to establish claims rising above speculation to prove medical bias, help bridge the gap to remedies for economic harm, and encourage medical practitioners to take a closer look at how they are evaluating patients. Such a policy would heighten the quality of prenatal care for Black women and can help garner social trust in the ability of the medical and legal system to better account for Black bodies

²⁸⁴ See Buckwalter-Poza, *supra* note 120.

²⁸⁵ Information is de-identified if "a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable" applies such methods and determines that it cannot be used to identify an individual who is a subject of the information or the listed identifiers are removed. 45 C.F.R. § 164.514(b) (2000).

²⁸⁶ See 45 C.F.R. § 164.512(a)(1) (2000); see also Troy Parks, *Sharing Health Data: HIPAA May Allow More Freedom Than You Think*, AM. MED. ASS'N (Mar. 18, 2016), <https://www.ama-assn.org/practice-management/hipaa/sharing-health-data-hipaa-may-allow-more-freedom-you-think>, archived at <https://perma.cc/5CF3-M95H>.

and health care. This innovation would begin the work of ending the cycle of generational harm.

i. Administrative Burdens and Overexposure to Liability for Physicians

If racial bias in medicine is so widespread and if it is possible for physicians to harbor such bias unconsciously, there might be concern that a change like this would overexpose physicians to liability. Ultimately, this is a balancing act between societal burdens and those who are best situated to carry them. Physicians have taken an oath not to do harm to their patients.²⁸⁷ They are learned professionals and rightfully are held to a higher standard than the average person.²⁸⁸ Thus, physicians are better suited to carry the burden of liability than are their Black female patients, who are disproportionately low-income and, like most people, unlikely to possess detailed medical expertise.

Similarly, hospitals are in a strong strategic and financial position to collect and organize information like PHI. Even in the case that it adds another administrative burden, physicians and hospitals are better able to produce this necessary evidence, as opposed to injured patients who may already be fighting an uphill financial battle to obtain appropriate evidence to make a case. This idea feels especially legitimate considering that much of the systemic medical bias that caused Black women to sustain injury was perpetuated by the U.S. medical system, which as discussed earlier, profited from Black women's injuries and exploitation. Surely, an administrative burden is worth the life and limbs of generations of Black Americans. Further, the aforementioned Medical Bias Accountability Initiative would not demand a drastic adjustment in the way that claims are litigated. A simple change in how we acquire information about medical bias in legal suits would only slightly shift the burden of production. A patient must still prove her case and convince a jury beyond a reasonable doubt that she is entitled to damages.

This suggestion is far from perfect. In fact, the solution to an issue as complex as this likely involves a multifaceted approach to reform, including legislative action, grassroots advocacy, awareness campaigns, new structures to hold physicians accountable, and education for vulnerable populations unaware of their legal rights and options. But together, these efforts can begin to create a medical and legal environment that is more understanding of and responsive to the trauma of Black women.

²⁸⁷ See *The Hippocratic Oath*, NAT'L INST. OF HEALTH, https://www.nlm.nih.gov/hmd/greek/greek_oath.html, archived at <https://perma.cc/R5WU-HQJH>.

²⁸⁸ See generally John Wade, *Public Responsibilities of the Learned Professions*, 21 LA. L. REV. 130, 130 (1960).

CONCLUSION

Black people have often been thought not to feel pain in the same way as people of other races. They face many challenges in accessing healthcare, pharmacies, and appropriate pain relief. While many sources explore why it is hard for Black people to obtain adequate health care, this article examines the efficacy of options for recourse once they have suffered an injury after receiving care and evaluates to what extent those options provide redress to make the patient whole. This article has particularly focused on the Black woman as she faces unique challenges in navigating healthcare and enduring emotional and psychological, generational, physical, and economic harms.

Because Black women are so much more likely than their counterparts to die due to medical issues such as childbirth complications or breast cancer, there should be more of a legislative focus on creating safeguards for this vulnerable population. What happened to Kira Johnson is a familiar story to many minorities, but it especially resonates with Black women and those who love them.²⁸⁹ In a country where so many vulnerable populations distrust the legal system and do not know what legal tools they have at their disposal, it is important to take a critical eye to viable options and build on what we have in order to create a more equal and productive society.

²⁸⁹ Nina Martin, *Black Mothers Keep Dying After Giving Birth*, NPR (Dec. 7, 2017), <https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why>, archived at <https://perma.cc/5UAY-PKVZ> (mentioning other victims such as Shalon Irving); see generally *Severe Maternal Morbidity in New York City, 2008-2012*, NYC DEP'T OF MENTAL HEALTH & HYGIENE, <https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf>, archived at <https://perma.cc/W9UG-FWAP> (showing the statistics underlying the large amount of minorities who have experienced the same trauma as Kira Johnson); see generally Marc Hurlbert, *Why Black Women Are More Likely to Die of Breast Cancer*, BREAST CANCER RES. FOUND. (Oct. 4, 2016), <https://www.bcrf.org/blog/why-black-women-are-more-likely-die-breast-cancer>, archived at <https://perma.cc/65LE-T2S4> (explaining how Black women are more likely to die from breast cancer, thus exposing more minorities to traumatic experiences in health care).