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FUNDAMENTALS OF HEALTH LAW

## U.S. Law and Discrimination in Health Care

Kimani Paul-Emile, J.D., Ph.D.

**D**iscrimination in health care can take several forms. One form, for example, looks like this: two patients, one Latinx and one non-Latinx White, enter a hospital with similar symptoms, and

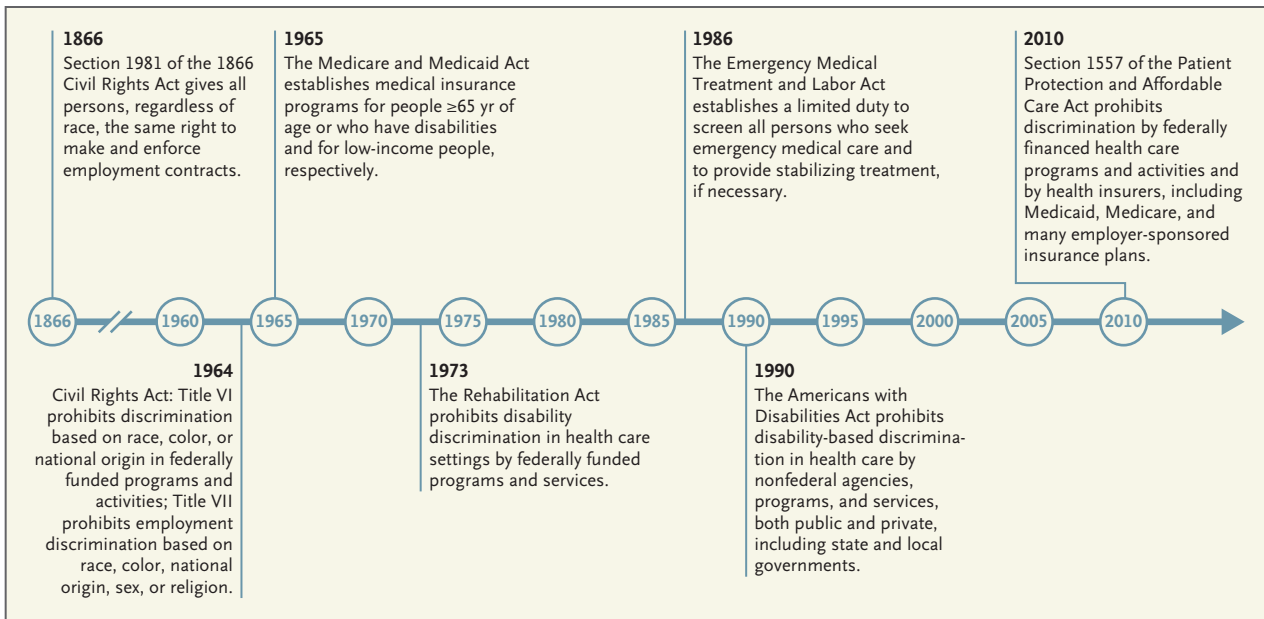
the physician who sees them suspects that both have congestive heart failure. The physician admits the White patient to a cardiology service but admits the Latinx patient to a general medicine service, even though admission to cardiology has been shown to yield better health outcomes, significantly reducing rates of readmission within 30 days. Another form of discrimination may present this way: a Black pediatric resident enters an examination room and introduces herself to her 8-year-old patient. When the resident bends down to give the child a high-five, the patient's father exclaims, "Don't you touch my child! I want a White doctor!"

Although discrimination both by clinicians and by patients and families is well documented, occurs relatively commonly, and may be based on characteristics other than race, the laws that can be used to address these two types of discrimination differ substantially.

In 1964, focusing on discrimination perpetrated by clinicians, Congress enacted Title VI of the Civil Rights Act, which targeted long-standing racial segregation in health care by prohibiting discrimination on the basis of race, color, or national origin by any program or activity receiving federal financial assistance (see timeline). The statute proscribes both intentional discrimination

and disparate-impact discrimination, which occurs when a policy or practice that seems neutral on its face has a discriminatory effect. Courts, however, have limited individuals' right to take legal action in cases of intentional discrimination, holding that only the Department of Health and Human Services Office of Civil Rights can enforce Title VI's disparate-impact provisions.

Sanctions for violations of Title VI are substantial and can be as severe as withdrawal of all federal funds from the entire offending health care institution. The 1965 Medicare and Medicaid Act, under which health care providers and facilities began receiving reimbursement from the government for care provided to indigent patients, lent greater force to Title VI, since nearly all U.S. health care facilities accept such funds. The combination of these laws has thus helped to



Key Laws Affecting Health Care Discrimination in the United States.

end state-sanctioned segregation in medical centers and substantially reduced the incidence of overt discrimination.

Persons with disabilities are protected from discrimination in health care by the Americans with Disabilities Act (which applies to nonfederal agencies, programs, and services, both public and private, including state and local governments) and the Rehabilitation Act of 1973 (which applies to federally funded programs and services). These laws safeguard people from disability-based discrimination if, despite their disability, they are qualified for the job, service, or program in question. In the health care setting, both laws ban discrimination when the patient's ability to benefit from a given service is unrelated to their disabling condition. Thus, people with paraplegia cannot be denied immunizations, since the ability to benefit from vaccinations is not affected by paralysis. Clinicians may take a disability into ac-

count, however, if it significantly compromises a patient's ability to benefit from treatment. Hence, metastatic cancer may disqualify a patient from receiving an organ transplant.

If reasonable accommodations can mitigate the disqualifying aspects of a disability, and the accommodations are not too costly, then reasonable accommodations must be undertaken by the program or service. For example, if counseling services would enable a patient with Down's syndrome who needs a kidney transplant to attend follow-up appointments and adhere to therapies, then the services would have to be offered as a reasonable accommodation, since they would improve the patient's ability to benefit from the transplantation.

These laws, though effective in reducing overt discrimination, were less effective against less explicit forms of discrimination, such as stereotyping, implicit bias, and prejudice. Many hospi-

tals, for example, continued to reject patients on the basis of their perceived inability to pay—a common proxy for many types of prohibited discrimination. To tackle this problem, in 1986, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA). This federal “anti-patient-dumping” statute applies to hospitals with emergency departments and establishes a limited duty to screen all persons who seek emergency medical care and provide stabilizing treatment if necessary. Although EMTALA does not mention race, ethnicity, or disability, it covers anyone who is denied or given a substandard medical screening and thus has the potential to address many forms of discrimination.

In 2010, Congress enacted the historic Patient Protection and Affordable Care Act (ACA), which made health insurance available to approximately 20 million additional Americans and provided more expansive protection from discrimination than does Title

VI. Section 1557 of the ACA prohibits discrimination by federally financed health care programs and activities, as well as health insurers including Medicaid, Medicare, and many employer-sponsored insurance plans. Section 1557's protections are broad, applying not only to discrimination based on race, color, national origin, and disability, but also to age and sex, including pregnancy status, sexual orientation, gender identity, and sex characteristics. In addition, the ACA requires health care providers and insurers to collect and report data on the racial and ethnic background of their patient populations, as well as on the languages they speak, as part of efforts to reduce segregation and disparities in the provision of health care services.

At the same time, discrimination in health care is not perpetrated only by clinicians. Some patients discriminate against clinicians, though this well-documented phenomenon has received comparatively little attention until recently.<sup>1</sup> Such discrimination can manifest in many ways, from explicit rejection of one's assigned clinician on the basis of their race, ethnicity, sex, gender, disability status, or religion, to nonverbal derision, to racist or biased remarks. Patients' expressions of bias can have substantial negative effects, including undermining the clinician-patient relationship; degrading the affected clinician; and inflicting substantial psychological and emotional harm, which contributes to burnout.

However, unlike discrimination perpetrated by clinicians, which is clearly prohibited by antidiscrimination laws, discrimination by patients lacks a clear

legal solution since it is subject to several different, often competing, legal rules. Indeed, although patients, clinicians, and medical centers have rights and obligations that are implicated in these cases, those rights and obligations frequently conflict. Patient bias, therefore, presents vexing clinical, legal, and ethical challenges that have no easy answers.

Title VI and the ACA, for example, cover only discrimination by health care workers and facilities. And while EMTALA protects patients from being denied emergency care, it also imposes on medical centers a duty to provide

VII of the 1964 Civil Rights Act, which bars race-, sex-, and religion-based discrimination in employment; and Section 1981, which prohibits race-based discrimination in contractual relationships and thus covers independent contractors.

Further complicating matters is the fact that some patients' requests for a clinician of a different race or ethnicity may be clinically important and thus worthy of accommodation — for instance, when patients seek cultural or language concordance, or have post-traumatic stress disorder that may be triggered by a

***Unlike discrimination perpetrated by clinicians, which is clearly prohibited by antidiscrimination laws, discrimination by patients lacks a clear legal solution.***


stabilizing treatment. In addition, patients have the right to informed consent, which encompasses their right to refuse desired medical care from a particular clinician. As a result, medical centers cannot simply tell patients in emergency situations to accept their assigned clinicians or seek treatment elsewhere, since doing so could violate EMTALA, and since such unwanted touching could constitute battery. But neither can medical centers continually compel workers to treat or forgo treating patients who have rejected them on the basis of social identity characteristics, because that could create a hostile work environment in violation of a host of state, local, and federal antidiscrimination laws, including Title

clinician's ethnic background, as might be the case for a veteran whose assigned clinician reminds her of a former enemy combatant.

Taken together, these divergent rights, interests, and obligations can put medical centers in a bind. If institutions accommodate patients' demands for different clinicians based on legally protected characteristics, they may be discriminating against the assigned clinicians in violation of employment antidiscrimination laws. But if they refuse to accommodate patients' demands, they may contravene laws against battery by forcing patients to be treated by rejected clinicians. And if the medical center does not screen and stabilize patients, it may violate EMTALA.

The law offers no silver bullet

for eliminating discrimination in this context. Similarly, although antidiscrimination laws have substantially reduced discrimination by clinicians, such discrimination remains an enduring problem, contributing to persistent health disparities. Ethical guide-

 **An audio interview with Kimani Paul-Emile is available at NEJM.org**

lines that include advice on devising appropriate supports for affected clinicians and training for all staff can offer important insight into ways of balancing effectively the rights and interests of patients, clinicians, and medical centers in the context of patient bias.<sup>2</sup> Any meaningful solution to both

patient and clinician discrimination, however, must also involve the medical profession's explicit acknowledgment of the existence of bias, racism, and structural inequality and their detrimental effects on health and health care. It will also require educating students, trainees, and staff about identifying and addressing bias on the parts of both patients and physicians; improving cultural awareness so that clinicians can engage more effectively with diverse patients; and expanding diversity among clinicians. Together, these measures can increase patient satisfaction, support clinicians, and promote tolerance

and understanding, which all foster better health outcomes.

The series editors are Erin C. Furse Brown, J.D., M.P.H., Aaron S. Kesselheim, M.D., J.D., M.P.H., Debra Malina, Ph.D., Geneva Pittman, M.P.H., and Stephen Morrissey, Ph.D.

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From Fordham University School of Law, New York.

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## Enhancing Regulations to Reduce Exposure to PFAS — Federal Action on “Forever Chemicals”

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In response to growing concerns over perfluoroalkyl and polyfluoroalkyl substances (PFAS), the Environmental Protection Agency (EPA) in March 2023 proposed national standards that would limit concentrations of six PFAS in public drinking-water supplies. This action is part of the Biden administration's plan for addressing PFAS pollution in the United States, a multiagency effort by the EPA, the Food and Drug Administration (FDA), the Department of Agriculture (USDA), the Department of Defense, and the Department of Health and Human Services. Establishing and enforcing these maximum contaminant levels for drinking water are necessary first steps in reducing the health effects of these persistent, pervasive, and toxic substances, which are linked to health care costs of at least \$5.5

billion annually in the United States.<sup>1</sup>

Thousands of individual PFAS are used in oil- and water-repellent textiles, personal care products, firefighting foams, food packaging, medical products, and countless other products, in part because the perfluorocarbon component feature that defines PFAS (e.g.,  $-C_nF_{2n}-$ ) results in chemical and physical properties not found in other substances.<sup>2</sup> The particularly strong nature of the carbon-fluorine bond makes these substances resistant to degradation, and some PFAS are thought to persist in the environment for thousands of years. PFAS have therefore been dubbed “forever chemicals.”

Past and current PFAS exposures pose threats to human health. In addition to their persistence in the environment,

many PFAS linger in people's blood for years after exposure. Nearly all Americans have detectable levels of PFAS in their blood. Americans are exposed to PFAS in their food, drinking water, and indoor dust and air. Epidemiologic and toxicologic studies have linked PFAS to some cancers, elevated cholesterol, impaired vaccine response, thyroid dysfunction, liver disease, reduced birth weight, and premature death, with no level of exposure being considered safe.<sup>3</sup> Particularly concerning are the health effects of exposure that occurs during gestation or early childhood, which may not manifest until years later and can include reduced immune responses to vaccines, lower bone mass, and cardiometabolic disease.<sup>3</sup>

In the United States, PFAS are used at more than 57,000 facili-