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BLACK LIVES MATTER: A CONVERSATION ON HEALTH AND CRIMINAL JUSTICE DISPARITIES

FRANCISKA COLEMAN* AND AVAL-NAREE S GREEN**

ABSTRACT

This article is written as a series of letters between a law professor and a medical doctor in reaction to the events surrounding the rise of the Black Lives Matter movement. The letters discuss the antebellum origins of health and criminal justice disparities and the cultural mistrust of doctors and law enforcement spawned by that history. The letters also briefly summarize institutional efforts undertaken to address both types of disparities, noting that these solutions have had limited efficacy due to their failure to address the symbiotic relationship between discretion, domination, and disparity. The article concludes with a recommendation to reduce both disparities and domination by establishing a non-discretionary minimum in health care and criminal justice.

Dear Dr. Green,

The summer of 2016 was the first time the two of us really had a serious conversation about the value of black lives in America. It was the summer Alton Sterling was shot point-blank in the chest while two NYPD officers held him pinned to the ground.¹ It was the summer Philando Castille died on a Facebook livestream after being shot in his own car, in front of his girlfriend and her child, while trying to comply with an officer's demand for ID.² It was the summer Charles Kinsey was shot

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¹ Catherine E. Schoichet, Joshua Berlinger & Steve Almasy, *Alton Sterling Shooting: Second video of deadly encounter emerges*, CNN (last updated July 6, 2016, 11:13 PM), <https://www.cnn.com/2016/07/06/us/baton-rouge-shooting-alton-sterling/>.

² Elliott C. McLaughlin, *Woman streams aftermath of fatal officer-involved shooting*, CNN (last updated July 8, 2016, 4:57 AM), <https://www.cnn.com/2016/07/07/us/falcon-heights-shooting-minnesota/>.

while lying flat on his back in the street with his hands in the air, begging the police officers not to shoot him or his autistic patient.³ It was also the summer Donald Trump won the Republican nomination and asked “the blacks,” “what the hell [they had] to lose” by voting for him.⁴

Despite all the outrage, grief and protests that characterized that summer, we still found ourselves watching George Floyd desperately beg for his life for eight minutes and forty-six seconds, while the police officer sworn to protect and serve him dispassionately suffocated him to death.⁵ We still found ourselves grieving the loss of Breonna Taylor, whose only crime was being asleep inside her home when unannounced police broke down the door at midnight.⁶ Even now, we still find ourselves struggling to process the trauma of state sanctioned violence. One difference between now and then, however, is the added trauma of medical neglect, as decades of health disparities find expression in body bags and the sheer number of lives lost to COVID-19 in poor minority communities.⁷ Though individuals across the nation have recently begun to express shock and dismay at the disparities in COVID-19 deaths and police uses of force, the broader context of race, health and criminal justice in America suggests that such disparities are historically grounded and deeply rooted norms of American life.⁸

I. ANTEBELLUM ORIGINS OF HEALTH AND CRIMINAL JUSTICE DISPARITIES

We live in a nation in which the first professional law enforcement officers were the slave patrols created to prevent slave revolts and maintain control of the slave populations in southern towns and cities.⁹

³ Catherine E. Shoichet, Joshua Berlinger & Sheena Jones, *Police accidentally shot man in North Miami, union says*, CNN (last updated July 22, 2016, 8:22 AM), <https://www.cnn.com/2016/07/21/us/miami-officer-involved-shooting/>.

⁴ Max Ehrenfreund, *The problem with Trump's question to black voters, 'What the hell do you have to lose?'*, WASH. POST (Aug. 24, 2016, 6:00 AM), <https://www.washingtonpost.com/news/wonk/wp/2016/08/24/the-problem-with-trumps-question-to-black-voters-what-the-hell-do-you-have-to-lose/>.

⁵ Evan Hill, et al., *How George Floyd Was Killed in Police Custody*, N.Y. TIMES (last updated Aug. 13, 2020), <https://www.nytimes.com/2020/05/31/us/george-floyd-investigation.html>.

⁶ Richard A. Oppel Jr., Derrick Bryson Taylor & Nicholas Bogel-Burroughs, *What to Know About Breonna Taylor's Death*, N.Y. TIMES (last updated Oct. 30, 2020), <https://www.nytimes.com/article/breonna-taylor-police.html>.

⁷ Maria Godoy & Daniel Wood, *What Do Coronavirus Racial Disparities Look Like State By State?*, NPR (May 30, 2020, 6:00AM), <https://www.npr.org/sections/health-shots/2020/05/30/865413079/what-do-coronavirus-racial-disparities-look-like-state-by-state>.

⁸ See *infra* Section I.

⁹ Carol S. Steiker, *Second Thoughts About First Principles*, 107 HARV. L. REV. 820, 839 (1994).

Unfortunately, after the Civil War eliminated *slave* as a legal category, slave patrols did not disappear.¹⁰ They morphed into police departments and continued to view their mandate as controlling black bodies—particularly as African Americans fleeing the domestic terrorism of the rural South caused dramatic increases in the populations of cities.¹¹ Even after the Civil Rights Movement caused the dismantling of the South’s legally mandated racial hierarchy, racially disparate policing practices helped create a new, informal racial hierarchy that continues to limit the free movement of Africans-Americans in society.¹² For example, racial disparities in discretionary investigative stops reveal a level of surveillance of the African American community that is so disproportionate to their presence in the population, it functions as a tool of social control.¹³ Not only are members of the African American minority almost three times more likely to be stopped by the police than members of the European American majority,¹⁴ African Americans are also often uniquely vulnerable to demands that they justify their presence in the “common” spaces of society to the state.¹⁵ Moreover, the disconnect between this surveillance and wrong-doing is often highly tenuous. Police willingness to investigate such innocuous activities as sleeping¹⁶ and drinking ice tea¹⁷ when the accused are African Americans is often combined with under investigation of actual criminal activity when the perpetrators are white. For example, NAACP statistics note that though African Americans and European-Americans use drugs at similar rates, African Americans are imprisoned for drug charges at almost six times the rate

¹⁰ *Id.*

¹¹ *Id.*

¹² MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS* 27–28 (The New Press 2012); Kenya Downs, *FBI warned of white supremacists in law enforcement 10 years ago. Has anything changed?*, PBS (Oct. 21, 2016, 4:10 PM), <https://www.pbs.org/newshour/nation/fbi-white-supremacists-in-law-enforcement>.

¹³ See text accompanying notes 14–21.

¹⁴ William Y. Chin, *Racial Cumulative Disadvantage: The Cumulative Effects of Racial Bias at Multiple Decision Points in the Criminal Justice System*, 6 WAKE FOREST J.L. & POL’Y 441, 443 (2016) (citing CHARLES R. EPP ET. AL., *PULLED OVER: HOW POLICE STOPS DEFINE RACE AND CITIZENSHIP* 155 (Univ. Chi. Press ed., 2014)).

¹⁵ Carl Takei, *How Police Can Stop Being Weaponized by Bias-Motivated 911 Calls*, ACLU (June 18, 2018, 6:00PM), <https://www.aclu.org/blog/racial-justice/race-and-criminal-justice/how-police-can-stop-being-weaponized-bias-motivated>.

¹⁶ Cleve R. Wootson Jr., *A Black Yale student fell asleep in her dorm’s common room. A white student called the police*, WASH. POST (May 11, 2018, 7:07 AM), <https://www.washingtonpost.com/news/grade-point/wp/2018/05/10/a-black-yale-student-fell-asleep-in-her-dorms-common-room-a-white-student-called-police>.

¹⁷ Michael Futch, *Charges dismissed in Arizona Iced Tea arrest outside Fayetteville liquor store*, FAYETTEVILLE OBSERVER (last updated Feb. 5, 2015, 2:40 PM), <https://www.fayobserver.com/article/20150205/News/302059642>.

of European-Americans.¹⁸ These disparities skew surveillance towards intimidation and control of innocent minorities rather than deterrence of wrong doers. Moreover, the “social control” skew is aggravated by racially disparate uses of force.¹⁹ Police are more likely to use force against African Americans than any other group, even during minor traffic stops.²⁰ More disturbingly, police are more likely to shoot African Americans during stops than European Americans, and five times more likely to shoot an unarmed African American than an unarmed European-American.²¹

The social control skew of investigative stops also infects sentencing decisions. For example, in addition to being highly surveilled within society, African Americans are also more likely to be removed entirely from society and placed under the control of agents of the state.²² Not only are African Americans six times more likely to be sentenced to prison than European Americans, but sentences that European Americans would typically receive only for violent crimes are often imposed on African Americans for non-violent crimes.²³ Such sentencing practices have led to 1.5 million black men between the ages of twenty-five to fifty-four missing from daily life; there are only eighty-three black men for every 100 black women in this age group, compared to the 99:100 ratio for white men and women in the same age range.²⁴ Moreover, though African Americans comprise only thirteen percent of the population, they constitute almost half of those on death row.²⁵ Current trends also suggest that one in three African American men can expect to be imprisoned and, thus, barred from voting, as well as most employment and housing opportunities.²⁶

¹⁸ *Criminal Justice Fact Sheet*, NAACP, <https://www.naacp.org/criminal-justice-fact-sheet/> (last visited Oct. 21, 2019).

¹⁹ SHELLEY HYLAND, LYNN LANGTON & ELIZABETH DAVIS, BUREAU OF JUST. STAT., U.S. DEP’T OF JUST., PUB. NO. NCJ 249216, POLICE USE OF NONFATAL FORCE 2002–11, at 1 (2015), <https://www.bjs.gov/content/pub/pdf/punf0211.pdf>.

²⁰ *Id.* at 4.

²¹ Wesley Lowery, *Aren’t more white people than black people killed by police? Yes, but no.*, WASH. POST (July 11, 2016, 5:41 AM), <https://www.washingtonpost.com/news/post-nation/wp/2016/07/11/arent-more-white-people-than-black-people-killed-by-police-yes-but-no/>.

²² See ACLU, RACIAL DISPARITIES IN SENTENCING: HEARING ON RACISM IN THE JUSTICE SYSTEM OF THE UNITED STATES, 1–2 (2014), <https://www.aclu.org/other/aclu-submission-inter-american-commission-human-rights-racial-disparities-sentencing>.

²³ *Id.* at 1, 7–8.

²⁴ Justin Wolfers, David Leonhardt & Kevin Quealy, *1.5 Million Missing Black Men*, N.Y. TIMES (Apr. 20, 2015), https://www.nytimes.com/interactive/2015/04/20/upshot/missing-black-men.html?_r=0.

²⁵ DEATH PENALTY INFO. CTR., FACTS ABOUT THE DEATH PENALTY, <http://www.deathpenaltyinfo.org/documents/FactSheet.pdf> (Oct. 2, 2020).

²⁶ ALEXANDER, *supra* note 12.

All too often, these disparities are accepted as normal and constitutional outcomes in America.²⁷ However, what would we think of a world in which Germany had the death penalty and the majority of those it executed were Jews?²⁸ Or of a Germany in which one in three Jewish men were systematically barred from voting, employment, and housing? In America today, this is not merely a hypothetical.

Sincerely,
Franciska

Dear Professor Coleman,

My heart ached as I watched the killing of George Floyd and as I witnessed the devastating effect of COVID-19 on black families and communities. What many do not realize is that the call for black lives to matter must be extended to healthcare.

Just as you noted regarding criminal justice, the devaluation of black lives in medicine has its origins in America's history of slavery.²⁹ The systematic dehumanization combated by the Black Lives Matter movement was used to justify the use of slaves as subjects for dissection and medical experimentation. For example, Dr. J Marion Sims, who is considered the "father of modern gynecology," experimented on three Alabama slave women without anesthesia, each enduring over thirty agonizing procedures as he developed a technique for repairing vesicovaginal fistulas, or abnormal sinus tracts that develop between the bladder and the vagina.³⁰ Thomas Hamilton, a physician in Georgia, used a male slave to test remedies for heat stroke.³¹ His experiments involved putting the slave, naked, in a pit that had been heated to a very high temperature while Hamilton tested various remedies, hoping to use medication to enable the slaves to better withstand working in the heat.³² Each experiment ended only when the slave lost consciousness.³³

²⁷ See Barbara A. Schwabauer, *The Emmett Till Unsolved Civil Rights Crime Act: The Cold Case of Racism in the Criminal Justice System*, 71 Ohio St. L.J. 653, 663–64 (2010); See also Paul Butler, *The System Is Working the Way It Is Supposed to: The Limits of Criminal Justice Reform*, 104 Geo. L.J. 1419, 1424 (2016)

²⁸ Bryan Stevenson, *We need to talk about an injustice [speech]*, TED (March 1, 2012), https://www.ted.com/talks/bryan_stevenson_we_need_to_talk_about_an_injustice?language=en.

²⁹ See *supra* Part I.

³⁰ V.N. Gamble, *Under the shadow of Tuskegee: African Americans and health care*, 87 AM. J. PUB. HEALTH 1773, 1774 (1997).

³¹ *Id.*

³² *Id.*

³³ *Id.*

Unfortunately, these instances of medical malpractice against vulnerable African American communities did not end with slavery. The Tuskegee Syphilis Study from 1932 to 1972, which proposed to study the natural history of syphilis, caused public outcry when it became widely known that the African American men who were enrolled in the study had not been given proper informed consent.³⁴ Furthermore, these men were led to believe that they were receiving treatment for their disease, when in fact they were not, even though the disease is curable with penicillin (widely known since 1947).³⁵ This event, though experienced by only some African Americans, is believed to have significantly influenced mistrust of the medical profession (even among African Americans who do not know the specifics) because it is now a part of the cultural fiber and narrative.³⁶ More recently, in 1993, the Pentagon officially declassified medical experimentation performed on 60,000 soldiers to determine the effects of mustard gas and lewisite during World War II.³⁷ Investigation into the experimental protocols revealed that the test subjects were exclusively African American, Japanese-American, and Puerto Rican soldiers.³⁸ The Caucasian soldiers were used as the control group.³⁹ These chemicals cause cellular DNA damage, painful blisters, leukemia, skin cancer, and lung disease.⁴⁰ Again, no informed consent was obtained, and no follow-up medical care or treatment was given to the test subjects.⁴¹ With these and other human-rights violations against people of color, often mediated by medical professionals, it is clear why cultural mistrust is such a significant barrier to addressing healthcare disparities.

Moreover, an emerging body of literature suggests that, even today, physicians may improperly treat African Americans differently due to misperceptions about biological differences between African Americans and Caucasians. A recently published article in the *Proceedings of the National Academy of Sciences* highlights a study by Hoffman and colleagues that examines false beliefs held by medical students about biological differences among African Americans and Caucasian

³⁴ *Id.* at 1773.

³⁵ *Id.*

³⁶ Gamble, *supra* note 30, at 1776.

³⁷ Susan L. Smith, *Mustard Gas and American Race-Based Human Experimentation in World War II*, 36 J.L. MED. & ETHICS 517, 517 (2008).

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.* at 518.

⁴¹ *Id.*

Americans and how those false beliefs impact treatment decisions.⁴² For example, they asked participants to rate as true or false statements such as “black people’s skin is thicker than white people’s skin” and “black people’s nerve endings are less sensitive than white people’s nerve endings.”⁴³ The authors found that holding false beliefs about these biological differences correlated with beliefs that African Americans feel less pain.⁴⁴ Furthermore, this implicit racial bias in pain perception also correlated with racial bias in pain treatment recommendations.⁴⁵ In other words, medical students who held these beliefs were more likely to make recommendations that would undertreat pain in African Americans.⁴⁶

Thus, current disparities in health care and distrust toward medical professionals by members of the African American community are rooted in injustices and mistreatment that stretch from the antebellum period to the present day.⁴⁷ According to the 2014 National Healthcare Quality and Disparities Report, African Americans had worse access to healthcare on about half of the healthcare access measures compared with Caucasian Americans.⁴⁸ They also received worse care on one-third of quality measures.⁴⁹ For example, African American women over the age of forty are more likely to be diagnosed with advanced-stage breast cancer than their Caucasian counterparts.⁵⁰ African American smokers seen for primary care are less likely to get advice about smoking cessation than Caucasian smokers.⁵¹ According to a leading cause of death report published by the National Center for Health Statistics in 2005, if being African American were a separate cause of death

⁴² Kelly M. Hoffman et al., *Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites*, 113 PROC. NAT’L ACAD. SCIS. 4296, 4296 (2016).

⁴³ *Id.* at 4298.

⁴⁴ *Id.* at 4296.

⁴⁵ *Id.* at 4299.

⁴⁶ *Id.*

⁴⁷ Compare Gamble, *supra* note 30 (discussing medical mistreatment inflicted on the African American community starting in the antebellum period), with AGENCY FOR HEALTHCARE RSCH. & QUALITY, 2014 NAT’L HEALTHCARE QUALITY & DISPARITIES REP., no. 15–0007, at 11 (2015), <https://archive.ahrq.gov/research/findings/nhqdr/nhqdr14/2014nhqdr.pdf> (documenting present day healthcare disparities experienced by the African American community).

⁴⁸ AGENCY FOR HEALTHCARE RSCH. & QUALITY, 2014 NAT’L HEALTHCARE QUALITY & DISPARITIES REP., no. 15–0007, at 11 (2015), <https://archive.ahrq.gov/research/findings/nhqdr/nhqdr14/2014nhqdr.pdf>.

⁴⁹ *Id.* at 18.

⁵⁰ *Id.* at 20.

⁵¹ *Id.*

in the United States, it would rank in sixth place.⁵² The African American infant mortality rate is twice that of non-Hispanic whites.⁵³ African American women are three times more likely to have maternal complications and three-and-a-half times more likely to have low birthweight babies.⁵⁴ Non-Hispanic black women are twice as likely as non-Hispanic whites to receive late or no prenatal care, and the disparity in infant mortality between the two groups has more than doubled in the past decade.⁵⁵ Diabetes is a highly prevalent disease in the country for all races, due in part to the obesity epidemic.⁵⁶ Unfortunately, African Americans are sixty percent more likely to have been diagnosed with diabetes by a physician and twice as likely to die from diabetes as non-Hispanic whites.⁵⁷ African Americans also have higher complication rates associated with diabetes, being more likely to develop end stage kidney disease and peripheral arterial disease than their white counterparts.⁵⁸ When African Americans are seriously ill, fewer resources are used to care for them than other groups with similar illness severity.⁵⁹ All of these disparities contribute to the well-documented difference in life expectancy of African Americans compared with Caucasian Americans.⁶⁰ Although the gap has narrowed gradually from the peak of 7.1 years in 1993, the life expectancy of Caucasians (79.1 years) is still higher than that of African Americans (75.5 years), as indicated by the National Vital Statistics Report.⁶¹

⁵² Kevin Outterson, *Tragedy and Remedy: Reparations for Disparities in Black Health*, 9 DEPAUL J. HEALTH CARE L. 735, 741 (2005).

⁵³ Office of Minority Health, *Infant mortality and African Americans*, U.S. DEPT OF HEALTH AND HUMAN SERVICES (Nov. 8, 2019), <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23> (last visited Oct 21, 2019).

⁵⁴ *Id.*

⁵⁵ T.J. Mathews, Marian F. MacDorman & Marie E. Thoma, *Infant mortality statistics from the 2013 period linked birth/infant death data set*, 64 NAT'L VITAL STAT. REP. 1, 3 (2015).

⁵⁶ See Office of Minority Health, *Obesity and African Americans*, U.S. DEP'T OF HEALTH AND HUMAN SERVICES (2016) <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=25> (last visited Nov. 28, 2020).

⁵⁷ Office of Minority Health, *Diabetes and African Americans*, U.S. DEP'T OF HEALTH AND HUMAN SERVICES (2016) <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18> (last visited Oct. 21, 2019).

⁵⁸ Elias K. Spanakis & Sherita Hill Golden, *Race/Ethnic Differences in Diabetes and Diabetic Complications*, 13 CURRENT DIABETES REPS. 814, 823 (2013).

⁵⁹ Alfred F. Connors Jr. et al., *A controlled trial to improve care for seriously ill hospitalized patients. The study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT)*, 274 J. AM. MED. ASS'N 1591, 1598 (1995).

⁶⁰ Jiaquan Xu et al., *Deaths: final data for 2013*, 64 NAT'L VITAL STAT. REP. 1, 6 (2016).

⁶¹ *Id.*

Medical disparities are also evident in use of hospice and palliative care at the end of a patient's life.⁶² Each year, the National Hospice and Palliative Care Organization publishes a report that explores hospice utilization trends across settings and groups.⁶³ In 2017, Caucasian Americans comprised 82.5% of the patients served by hospice agencies in the United States compared with only 8.2% for African Americans.⁶⁴ This disparity is particularly striking because African Americans have poorer overall health, higher morbidity and mortality across disease states, and shorter life expectancy.⁶⁵ These issues point to a global disconnect in how African Americans experience the healthcare system through both life and death.

Many researchers have linked some of the healthcare disparities to deep-seated cultural mistrust held by the African American community toward the healthcare system, indicating that African Americans may be less likely to seek care in certain situations because of this lack of trust.⁶⁶ For example, the National Health Care Quality and Disparities Report shows that African Americans and their caregivers are still more likely to reject information about end-of-life care and hospice than Caucasians.⁶⁷ This suggests that the underrepresentation of African Americans in hospice is by choice. But what factors have contributed to these findings? According to Mazanec and colleagues, the African American heritage is one that is heavily influenced by the struggle for survival through years of oppression and a deeply held belief that life is sacred no matter the condition.⁶⁸ This cultural construct, coupled with mistrust, may be responsible for the desire of African Americans to pursue aggressive treatment rather than comfort care at the end of life and may explain why so few take advantage of hospice services.⁶⁹ In fact, deeply held cultural mistrust among African Americans toward the medical community and the widespread resistance to hospice services may be considered the original Black Lives Matter movement. End-of-life decision-making in healthcare is one of the few places where

⁶² See Polly M. Mazanec, Barbara J. Daly & Aileen Townsend, *Hospice Utilization and End-of-Life Care Decision Making of African Americans*, 27 AM. J. HOSPICE AND PALLIATIVE MED. 560, 560 (2010).

⁶³ See NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION, NHPCO FACTS AND FIGURES (2018), https://www.nhpco.org/wp-content/uploads/2019/07/2018_NHPCO_Facts_Figures.pdf.

⁶⁴ *Id.*

⁶⁵ Mazanec et al., *supra* note 62, at 561.

⁶⁶ *See id.* at 560–65.

⁶⁷ *Id.* at 561.

⁶⁸ *Id.*

⁶⁹ *Id.* at 561–62.

African Americans can unequivocally assert their humanity in the face of a system that seems to devalue the worth of their lives. African American patients and their families have the right to refuse hospice services. They also have the right to advocate for continued aggressive treatment even when physicians have determined that doing so is medically futile, a circumstance that often requires adjudication by an ethics committee.⁷⁰ The assertion of that right by African Americans over the years may have been a way of communicating the very principles embodied by the Black Lives Matter movement before there was a hashtag. Thus, the resistance of African American patients to hospice care is unlikely to change until the medical community addresses the causes and depth of this mistrust.

Sincerely,
Aval

II. INSTITUTIONAL EFFORTS TO ADDRESS DISPARITIES

Dear Dr. Green,

Professor Derrick Bell was known for insisting that racism is a permanent feature of America life,⁷¹ and your discussion of the ways in which current medical students continue to embrace false narratives of African American health “exceptionalism” provides sobering support for his view.⁷² I find it interesting that you suggest that one solution to the problem of devaluing black lives in the medical profession lies in remedying the cultural mistrust of doctors that is so prevalent in the African American community.⁷³ There is a similar distrust of law enforcement officers and prosecutors in the criminal justice context. However, the solutions to the issue of disparities in criminal justice have generally been pursued through the courts, though with limited success. One of the primary reasons for this can be traced back to 1987, when the U.S. Supreme Court held that statistical criminal justice disparities are largely non-justiciable.⁷⁴ In *McCleskey v Kemp*, McCleskey provided statistical evidence that murder defendants whose victims were white were 4.3 times as likely to receive the death penalty as defendants whose

⁷⁰ Thaddeus Mason Pope, *Dispute Resolution Mechanisms for Intractable Medical Futility Disputes*, 58 N.Y.L. SCH. L. REV. 347, 358 (2013–2014).

⁷¹ DERRICK BELL, *FACES AT THE BOTTOM OF THE WELL: THE PERMANENCE OF RACISM* (1992).

⁷² *See id.*

⁷³ *See supra* Part I.

⁷⁴ *McCleskey v. Kemp*, 481 U.S. 279, 319 (1987) (holding that legislative bodies are better equipped to consider the weight of statistical studies).

victims were black,⁷⁵ and that black defendants whose victims were white (like McCleskey himself) had the highest chance of receiving the death penalty of any group.⁷⁶ McCleskey argued that these racial disparities in the imposition of the death penalty violated the guarantee of equal protection.⁷⁷ The Court disagreed and held that statistical evidence of racial disparities in sentencing was not sufficient proof of intentional discrimination and thus did not constitute an equal protection violation, *despite accepting such proof in other contexts*.⁷⁸ The Court's decision to reject statistical evidence as proof of discrimination was rooted in a concern that to hold otherwise would indict the entire criminal justice system of the state (and the nation).⁷⁹ The court was unwilling to do that, and instead created a judicial precedent that denies institutionalized racial disparities.

At the same time, however, judges have been helpful when disparities and race-based social control tactics are framed as a local, rather than national, problem. For example, civil rights organizations have successfully challenged racial profiling practices in Philadelphia and New York City.⁸⁰ In 2010, the ACLU filed a class action lawsuit over racial profiling in Philadelphia.⁸¹ This resulted in a consent decree in which the city, though denying wrongdoing, nevertheless agreed to adopt remedial measures.⁸² The Philadelphia police department agreed to create an electronic database that would allow monitors to track the frequency with which racial minorities were stopped and frisked as well as the reasons given by the officers.⁸³ The department also agreed to require reviews of stop-and-frisk documentation by supervisors⁸⁴ and to change police training and policy manuals.⁸⁵ A similar lawsuit in New York City led to a court order that required the New York City police to adopt body cameras on a pilot basis.⁸⁶ It also ordered police to implement a

⁷⁵ *Id.* at 287.

⁷⁶ *Id.*

⁷⁷ *Id.* at 291.

⁷⁸ *Id.* at 297.

⁷⁹ *Id.* at 314–19.

⁸⁰ See Consent Decree, *Bailey v. City of Phila.*, No. 10-05952 (E.D. Pa., June 21, 2011), ECF No. 16; *Floyd v. City of New York*, 959 F. Supp. 2d 540 (S.D.N.Y. 2013); *Ligon v. City of New York*, 925 F. Supp. 2d 478 (S.D.N.Y. 2013).

⁸¹ ACLU Pennsylvania, *Bailey, et al. v. City of Philadelphia, et al.*, <https://www.aclupa.org/en/cases/bailey-et-al-v-city-philadelphia-et-al> (last visited Nov. 28, 2020).

⁸² Consent Decree, *Bailey*, No. 01-1491.

⁸³ *Id.*

⁸⁴ *Id.* at 4.

⁸⁵ *Id.*

⁸⁶ *Floyd v. City of New York*, 959 F. Supp. 2d 540, 563 (S.D.N.Y. 2013).

pilot program in which the officers issued “receipts” to stopped civilians, informing them of the reasons for the stop and providing the identity, badge number, and precinct of the officer stopping them.⁸⁷ These requirements were in addition to documentation and training provisions that mirrored those in the Philadelphia consent decree.⁸⁸

While the consent decrees and court orders in these cases represented a huge step forward in the battle against criminal justice disparities, they were limited by a background narrative that treated this level of racial profiling as an issue of these particular cities rather than as a pervasive national and structural norm. New York police officers and Philadelphia police officers were not engaging in behavior that was different from that of other police officers around the country.⁸⁹ This meant that translating new administrative policies of non-discrimination into changed police practices was complicated by the fact that the systemic discrimination that informed such practices remained a national norm.⁹⁰ As a result, the changes in police practice that were authorized at the supervisory level often failed in implementation on the ground level.⁹¹

The McCleskey Court, however, had not itself advocated for localized judicial review.⁹² Rather, it had defended its limited holding by suggesting that addressing systemic racial disparities in criminal justice is a legislative rather than judicial task.⁹³ State legislatures, however, have proven equally limited in their willingness to address these systemic disparities. The vehicle that has emerged in state legislatures for addressing criminal justice disparities is racial impact statements.⁹⁴ These statements require legislatures to consider the racial impact of bills modifying criminal laws and penalties.⁹⁵ Unfortunately, only eleven of the fifty states have proposed legislation authorizing racial impact statements, and, of those, only four have succeeded in actually

⁸⁷ *Id.*; *Ligon v. City of New York*, 925 F. Supp. 2d 478 (S.D.N.Y. 2013).

⁸⁸ *Ligon*, 925 F. Supp. at 544.

⁸⁹ Devon W. Carbado, *From Stopping Black People to Killing Black People: The Fourth Amendment Pathways to Police Violence*, 105 CAL. L. REV. 125, 128 (2017).

⁹⁰ *Id.*

⁹¹ *Civil Rights Attorneys: Racial Disparities Persist in NYPD Stop and Frisk*, CTR. FOR CONST. RTS. (June 9, 2017), <https://cctrjustice.org/home/press-center/press-releases/civil-rights-attorneys-racial-disparities-persist-nypd-stop-and>.

⁹² *McCleskey v. Kemp*, 481 U.S. 279, 319 (1987) (citing *Gregg v. Georgia*, 428 U.S. 153, 186 (1976)).

⁹³ *Id.*

⁹⁴ Jennifer M. Kirby-McLemore, *Combining Proactive and Reactive Methods to Address Racial Disparities in Incarceration Rates*, 9 S.J. POL’Y & JUST. 26, 27 (2015).

⁹⁵ *Id.*

passing legislation authorizing racial impact statements.⁹⁶ Moreover, only Iowa makes racial impact statements mandatory for changes in criminal justice laws,⁹⁷ while Minnesota prepares statements under certain conditions.⁹⁸ The other two states (Connecticut and Oregon) have a “by request” system that authorizes legislative committees to request the statements.⁹⁹ More significantly, however, racial impact statements are for informational purposes only; legislatures are not required to make any changes to proposed legislation based on the statements or even to explain their reasons for continuing with proposed legislation despite a finding of disparate racial impact.¹⁰⁰ As a result, the effect of racial impact statements is extremely limited.¹⁰¹

On the other hand, however, as the cost of our massive prison system places an increasing strain on state budgets, there have been efforts to reduce costs by reducing overall incarceration rates. These efforts often operate to reduce the over-incarceration of African American males—a classic example of Professor Bell’s interest convergence theory.¹⁰² For example, in recent years, budgetary crises have motivated states to reform parole and probation policies, making parole available earlier and reducing the use of re-incarceration as a penalty for technical parole violations.¹⁰³ Similarly, Congress and several states have taken steps to reduce mandatory minimum sentences.¹⁰⁴ In addition, though laws that directly reduce racial disparities in the criminal sentencing do exist, (for example, the law reducing the disparity in sentencing for possession of crack and powdered cocaine),¹⁰⁵ such examples are few and far between. This is especially true given that most sentencing disparities are the result of discretionary decisions, rather than differential treatment prescribed by law. For example, a recent study by Professors Starr and Rehavi found that a key contributor to racial disparities in sentencing was the fact that black defendants were twice as likely as white defendants to be charged with an offense carrying a mandatory

⁹⁶ Jessica Erickson, *Racial Impact Statements: Considering the Consequences of Racial Disproportionalities in the Criminal Justice System*, 89 WASH. L. REV. 1425, 1426-27 (2014).

⁹⁷ *Id.* at 1446-47.

⁹⁸ *Id.* at 1445-46.

⁹⁹ *Id.* at 1448-49.

¹⁰⁰ *Id.* at 1426.

¹⁰¹ *See id.*

¹⁰² Derrick A. Bell, Jr., *Brown v. Board of Education and the Interest-Convergence Dilemma*, 93 HARV. L. REV. 518, 523 (1980).

¹⁰³ David Cole, *Turning the Corner on Mass Incarceration?* 9 OHIO ST. J. CRIM. L. 27, 31 (2011).

¹⁰⁴ *Id.* at 29-30.

¹⁰⁵ Fair Sentencing Act of 2010, Pub. L. No. 111-220, 124 Stat. 2372, 21 U.S.C. §§ 841, 960 (2010).

minimum, even when there was no difference in the underlying arrest offense.¹⁰⁶ A growing public awareness of the impact of charging disparities has led to strong grassroots efforts to elect prosecutors committed to reducing such disparities,¹⁰⁷ reversing trends in which many prosecutors ran unchallenged for years.¹⁰⁸

Overall, I think that a focus on cultural mistrust similar to what you have suggested for healthcare disparities could lead to improved outcomes in criminal justice. Just as the problems of healthcare disparities spring from the tendency of doctors to treat African Americans as less than patients, criminal justice disparities spring from the tendency of the officers, prosecutors and judges to treat African Americans as less than citizens. The growing attempts to hold prosecutors accountable for charging decisions seems to be a key step in reducing such mistrust in the criminal justice context.

Sincerely,
Franciska

Dear Professor Coleman,

Unfortunately, if one thing has become clear over time in the medical field, it is that reducing the causes of cultural mistrust is an uphill battle. There are those in the medical establishment who acknowledge that, having been complicit in creating a healthcare environment that contributes to cultural mistrust of physicians among African Americans, it is important for the healthcare system to be part of the solution. There is a plethora of published literature in the medical and social sciences on healthcare disparities and medical mistrust. Indeed, a PubMed search for key words “medical mistrust” yields over 600 articles spanning 1976 to present.¹⁰⁹ A similar search for “healthcare disparities United States” yields over 6000 articles, the majority of which

¹⁰⁶ Sonja B. Starr & M. Marit Rehani, *Mandatory Sentencing and Racial Disparity: Assessing the Role of Prosecutors and the Effects of Booker*, 123 YALE L.J. 2, 7 (2013).

¹⁰⁷ Paige St. John & Abbie Vansickle, *Prosecutor Elections Now a Front Line in the Justice Wars*, THE MARSHALL PROJECT (May 23, 2018, 6:00AM), <https://www.themarshallproject.org/2018/05/23/prosecutor-elections-now-a-front-line-in-the-justice-wars>.

¹⁰⁸ Evan Hughes, *America's Prosecutors Were Supposed to Be Accountable to Voters. What Went Wrong?*, POLITICO MAG. (Nov. 5, 2017), <https://www.politico.com/magazine/story/2017/11/05/cyrus-vance-jr-americas-prosecutor-problem-215786>.

¹⁰⁹ Search Results for “medical mistrust”, PUBMED, <https://pubmed.ncbi.nlm.nih.gov/?term=%22medical+mistrust%22>.

have been published in the last ten years.¹¹⁰ A Boolean search combining the two queries yields far fewer results (thirty-three), while searching for “healthcare disparities United States AND racial bias” yields 437 results, each dating back to only 2002.¹¹¹ This demonstrates the fact that the primary focus of the medical community has been on diagnosing the problem of healthcare disparities with only recent exploration of the possibility that such disparities may be driven in large part by racial bias and the medical distrust it engenders.

In 1999 the US Congress charged the Institute of Medicine with assessing the extent of racial and ethnic disparities in healthcare, uncovering sources of those disparities, and suggesting solutions.¹¹² When the Institute of Medicine published its report in 2003, it was scathing. It demonstrated that, even when controlling for potential confounders such as insurance status and disease severity, minorities are less likely than whites to receive necessary medical services and procedures, and they are more likely than whites to have poor outcomes.¹¹³ These disparities held true across disease categories and across healthcare settings; furthermore, the inequities yielded not only lower-quality healthcare but also higher mortality for minorities.¹¹⁴

In the wake of that report, we have seen a sharp increase in publications dealing with racial bias and how it affects treatment decisions and outcomes in healthcare. We are now beginning to understand through the literature that both explicit and implicit attitudes affect perceptions and behavior of both patients and physicians in healthcare situations. For example, in one 2007 study, researchers showed that white physicians with more negative implicit bias toward blacks as being “uncooperative” patients were less likely to prescribe thrombolytic drugs to black patients.¹¹⁵ Being aware that these implicit biases exist and that they affect how healthcare is delivered to different ethnic and racial groups is a very important first step. Embracing this truth enables the medical community to make efforts to train healthcare providers in ways

¹¹⁰ Search Results for “healthcare disparities United States”, PUBMED, <https://pubmed.ncbi.nlm.nih.gov/?term=healthcare+disparities+United+States>.

¹¹¹ Search Results for “medical mistrust” “healthcare disparities United States”, PUBMED, <https://pubmed.ncbi.nlm.nih.gov/?term=%22medical+mistrust%22+%22healthcare+disparities+united+states%22>; Search Results for “healthcare disparities united states AND racial bias”, PUBMED, <https://pubmed.ncbi.nlm.nih.gov/?term=%22healthcare+disparities+united+states+AND+racial+bias%22&filter=years.2002-2020&timeline=expanded>.

¹¹² INSTITUTE OF MEDICINE, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 3 (2003).

¹¹³ *Id.* at 2–3.

¹¹⁴ *Id.*

¹¹⁵ Alexander R. Green et al., *Implicit Bias Among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 J. OF GEN. INTERNAL MED. 1231 (2007).

that mitigate the effects of implicit bias. The Liaison Committee on Medical Education (LCME) is recognized by the U.S. Department of Education as the accrediting body for medical schools in both the United States and Canada.¹¹⁶ It is jointly sponsored by the American Association of Medical Colleges and the American Medical Association.¹¹⁷ In 2000, the LCME introduced a standard for cultural competence curricula in medical schools aimed at helping medical students learn to recognize and appropriately address gender and cultural bias in healthcare delivery.¹¹⁸ This provision is now a condition of accreditation.¹¹⁹

The healthcare community has also explored system-level factors that influence how healthcare is delivered. Examples include insurance coverage, geographic distribution of medical providers, and other issues that may serve as barriers to healthcare. While these factors are not racially mediated, many of them disproportionately affect African Americans and other minorities.¹²⁰ The Affordable Care Act was signed into law in 2010 with a goal of improving the quality, accessibility, and affordability of healthcare.¹²¹ According to the Kaiser Family Foundation, the rate of uninsured dropped from 17.8% in 2010 to ten percent by 2016, and most of the coverage gains were mediated by Medicaid expansion in the states that chose to participate.¹²² Disparities persist, however and by 2018, the rate of uninsured African Americans was eleven percent compared to eight percent for White Americans.¹²³ While improving rates of insurance coverage is an important goal, we must also improve the quality of care available to all Americans. This requires attention to inequities in healthcare—not merely those rooted

¹¹⁶ *Scope and Purpose of Accreditation*, LIAISON COMM. ON MED. EDUC., <https://lcme.org/about/>.

¹¹⁷ *Id.*

¹¹⁸ *Cultural Competence Education*, ASS'N OF AMERICAN MED. COLLS. 1 (2005), <https://www.aamc.org/media/20856/download>.

¹¹⁹ *Id.*

¹²⁰ Valire Carr Copeland, *African Americans: Disparities in Health Care Access and Utilization*, 30 HEALTH & SOC. WORK, no.3, 2005, at 265–70.

¹²¹ Affordable Care Act, 42 U.S.C. § 18001 (2010).

¹²² Rachel Garfield et al., *The Uninsured and the ACA: A Primer – Key Facts about Health Insurance and the Uninsured Amidst Changes to the Affordable Care Act*, KAISER FAMILY FOUND. (Jan. 25, 2019), <https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-many-people-are-uninsured/#:~:text=When%20the%20major%20ACA%20coverage,before%20the%20ACA%20was%20passed>.

¹²³ *Uninsured Rates for the Nonelderly by Race/Ethnicity*, KAISER FAM. FOUND., <https://www.kff.org/uninsured/state-indicator/rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Oct. 21, 2019).

directly in racial bias of the medical profession but also those innumerable barriers to access that are a function of cultural mistrust.

Yours truly,
Aval

III. REDUCING DISPARITIES BY REDUCING SYSTEMIC DOMINATION

Dear Dr. Green,

I agree that in order to fully address criminal justice disparities and healthcare disparities, we cannot merely focus on individuals as victims of inequality. We must focus on removing barriers that prevent individuals from escaping victimization and the cycle of inequality through their own efforts. We must do more to reduce disparity than make patients and suspects the objects of another's well-intentioned advocacy; we must create the conditions under which they can be their own advocates against disparity. This means that we must address the fact that the vast majority of groups experiencing disparate outcomes in healthcare and criminal justice lack autonomy in their healthcare and legal choices and are dependent on the charity of others for their most basic medical and legal needs. The criminal justice context provides a stark example. Individuals who have been convicted of crimes are completely disenfranchised for life in many states, directly and through what has been called documentary disenfranchisement.¹²⁴ This means that, after being released from the domination of prison officials, they remain under the permanent dominion of their fellow citizens, dependent upon the goodwill of others for access to the most basic necessities of life. Moreover, they may be freely discriminated against in housing, education, employment, and access to social welfare.¹²⁵ They may also be stopped and searched by police at any time for no greater reason than their former criminality.¹²⁶ They have no personal security and are deprived of any avenue to obtain such security as they have no vote and, thus, no voice and no representation. Thus, disparities in criminal justice seem rooted as much in the powerlessness of minorities stigmatized as criminals as in the prejudice or bias of institutions, with cultural mistrust being the product of decision-making under these two conditions.

¹²⁴ Jessie Allen, *Documentary Disenfranchisement*, 86 Tul. L. Rev. 389, 393–94, 414 (2011).

¹²⁵ Dorothy E. Roberts, *The Social and Moral Cost of Mass Incarceration in African American Communities*, 56 Stan. L. Rev. 1271, 1291 (2004).

¹²⁶ See generally *Whren v. United States*, 517 U.S. 806 (1996) (upholding pretextual searches and seizures).

The continuing denials of equal citizenship despite constitutional promises to the contrary have led many African Americans to distrust the utility of voting in the same way many African American patients distrust doctors and hospice care. Abstaining from voting can represent a refusal to participate in (and thus consent to) their marginalization and electoral domination.¹²⁷ As a result, the only way to make lasting changes in terms of healthcare disparities is to reduce the patient mistrust of the healthcare system by addressing the issues that continually reproduce that mistrust. Similarly, the only way voting and legislation can meaningfully impact criminal justice disparities is if the issues that continually reproduce the cultural mistrust of democracy and depress the African American vote must be addressed.

In that respect, autonomy must be a key component of any approach to the reduction of racial disparity that takes cultural mistrust seriously. By autonomy, I mean that individuals must have some minimum level of security in the area of healthcare and criminal justice that is independent of the discretionary will of others.¹²⁸ In the current structure, for most poor minorities, there is no claim to health care or justice that is not completely dependent on the discretionary will of employers and insurance functionaries (health care) or the will of neighbors and police officers (criminal justice). It is this relatively unbridled discretion, in the name of freedom of contract and executive privilege, that facilitates disparities and serves as a breeding ground for the prejudice and mistrust that exacerbate them.

In order to reduce disparities, then, there must be some level of healthcare that cannot be denied regardless of employment status and insurance evaluation. There must also be some level of personal security that cannot be invaded, regardless of how suspicious one's neighbors are or how risk-averse a given police officer is. In my view, lasting reductions in racial disparities require more than new policies, more documentation, and anti-bias training (though those are all very important). It requires increases in the autonomy and the empowerment of citizens by providing secure access to certain non-discretionary minimums. The new trend towards prosecutorial candidates attuned to the equal justice demands of vulnerable communities seems to be a promising first step,

¹²⁷ Asma Khalid, *Some Young Black Activists Say They Won't Vote for President*, NPR (June 22, 2016), <https://www.npr.org/2016/06/22/483046639/why-many-young-black-activists-see-no-reason-to-vote-for-president>.

¹²⁸ PHILIP PETTIT, *JUST FREEDOM: A MORAL COMPASS FOR A COMPLEX WORLD* 4–5 (1st ed. 2014).

but it must be supported by ballot access and community input on policing policies and practices.¹²⁹

Sincerely
Franciska

Dear Professor Coleman,

Your focus on autonomy drives home the impact on African Americans of living at the intersection of systemic racism across every major institution in our society. Indeed, autonomy is one of the four basic ethical principles we use to guide modern day healthcare delivery, along with justice, beneficence, and non-maleficence.¹³⁰ One could argue that where racial disparities in healthcare are concerned, we are in violation of all four ethical principles to varying degrees. Simply put, these imperatives require a healthcare system that respects the right of individuals to maintain control over what happens to them, aims to provide benefit, seeks to do no harm, and makes every effort to achieve fairness in access and delivery. Our medical training teaches us to diagnose, triage, and treat. We now have an abundance of data describing the “societal illness” of race-related disparity, including increased mortality for African Americans.¹³¹ In essence, the diagnosis has been made and the urgency has been established. People are dying.

If our society harbored any doubt in its collective consciousness about the presence and impact of racial inequities on health outcomes, we have been given the opportunity to view this phenomenon through the magnifying lens of the global COVID-19 pandemic. African Americans are more likely to hold essential jobs that cannot be done from home, putting them at greater risk of contracting the virus.¹³² Current evidence suggests that African Americans are five times more likely to require hospitalization related to the novel coronavirus infection than non-Hispanic Whites.¹³³ Furthermore we see disproportionate COVID-

¹²⁹ Franciska Coleman, *Between the “Facts and Norms” of Police Violence: Using Discourse Models to Improve Deliberations Around Law Enforcement*, 47 HOFSTRA L. REV. 489 (2018).

¹³⁰ Katie Page, *The Four Principles: Can They Be Measured and Do They Predict Ethical Decision Making?*, BMC MED. ETHICS 1 (2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3528420/pdf/1472-6939-13-10.pdf>.

¹³¹ Ravina Kullar et al., *Racial Disparity of Coronavirus Disease 2019 in African American Communities*, 222 J. INFECTIOUS DISEASES, no. 6, 2000, at 890–93.

¹³² Irina Ivanova, *As States Reopen, Black Workers Are at Greater Risk for COVID-19*, CBS NEWS (June 16, 2020), <https://www.cbsnews.com/news/black-workers-lives-essential-frontline-jobs-risk-coronavirus-reopening/>.

¹³³ CTR. FOR DISEASE CONTROL AND PREVENTION, HEALTH EQUITY CONSIDERATIONS AND RACIAL AND ETHNIC MINORITY GROUPS (July 24, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>.

19 death rates among African Americans nationwide, with mortality rates double what would be expected given their proportion of the US population.¹³⁴ When the initial COVID-19 data emerged clarifying yet another example of healthcare disparities in which African Americans suffer disproportionately, my heart ached again. I am an African American healthcare worker with a chronic medical condition and familial risk factors for cardiovascular disease. I am worried about my family and those closest to me. So far, we've buried my uncle, a close family friend and three church members. Were the deaths directly related to COVID-19 or indirectly related to the inequities in healthcare access the pandemic has exacerbated? The answer to that question is unknown, but we mourn, nonetheless.

We are now challenged to offer an effective prescription. As you suggest, everyone must be guaranteed certain "non-discretionary minimums."¹³⁵ Access to basic healthcare is a good example, and we must decisively settle the debate in favor of its classification as a fundamental right as opposed to a privilege. This important first step is required to ensure success in closing the healthcare coverage gap that underscores so many of the disparities we now see. Doing so will lay the necessary foundation for equity across socio-economic and racial barriers on which we can build. Furthermore, we need to sustain our focus on health inequities by ensuring that our quality reporting process includes metrics related to rates of goal concordant care based on race and ethnicity. For example, reimbursement penalties for persistent gaps in care delivery would be a powerful incentive for continuous process improvement aimed at decreasing differences in healthcare outcomes based solely on race or ethnicity. Finally, another challenging, but essential component of the prescription is the relentless effort to identify and mitigate the effect of implicit bias on our healthcare delivery system. Accrediting bodies should require healthcare institutions to mandate annual implicit bias training for all healthcare workers. In addition, this education should not only address implicit bias in individual professional behavior, but it should also provide tools to aid in recognition and remedy of implicit bias in institutional policies and procedures. Academic medical programs should constantly strive to increase the diversity and retention of underrepresented groups in the healthcare workforce and in healthcare industry leadership across disciplines. Fostering a more diverse healthcare workforce requires anti-racism and anti-bias

¹³⁴ Maria Godoy & Daniel Wood, *What Do Coronavirus Racial Disparities Look Like State by State?*, NAT'L PUB. RADIO (May 30, 2020, 6:00 AM), <https://www.npr.org/sections/health-shots/2020/05/30/865413079/what-do-coronavirus-racial-disparities-look-like-state-by-state>.

¹³⁵ See *supra* Part III.

policies that are clearly stated, effectively communicated, and consistently enforced. Consequences shape behavior and behavior influences culture. Whether in criminal justice or in healthcare, when we change our culture, we will change our outcomes.

Yours truly,

Aval