A NEW STRATEGY TO COMBAT RACIAL INEQUALITY IN AMERICAN HEALTH CARE DELIVERY

Dayna Bowen Matthew[1]

"Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane."

\- Martin Luther King, Jr.

The statistical[2] and anecdotal[3] evidence of racial inequality in American healthcare is undisputable. Since 2003 when the Institute of Medicine report entitled "Unequal Treatment" widely circulated a compelling body of research and data to demonstrate systemic as well as clinical[4] discrimination,[5] health professionals, lawmakers, and

---

[1] Associate Professor and Associate Dean for Academic Affairs, University of Colorado School of Law. I am grateful for the support of the National Academy of Social Insurance for providing financial and intellectual support for this research. I am also indebted to Professor Timothy Jost for his support and for encouragement as he challenged my thinking on this project along the way. I thank Professors Emily Calhoun, Michele Goodwin, Melissa Hart, Pierre Schlag and Sidney Watson for their very helpful comments on earlier drafts. I owe Professor Goodwin special thanks for giving me a forum in which to present and discuss these ideas at the DePaul Institute of Health Law and Policy; she has been an inspiration and friend throughout this project. Finally, I owe a debt of thanks to my research assistant, Adam Romney whose exceptional research and hard work will be sorely missed as he graduates and begins his legal career this year. I will watch in wonder as you begin now to chart your stars, Adam; God's speed!

[2] *See* CENTER FOR HEALTH EQUITY RESEARCH AND PROMOTION, *Intro to Health Disparities Primer*, http://www.cherp.org/index.php.

[3] Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination – It Shouldn't Be So Easy*, 58 FORDHAM L. REV. 939, 939 (1990). Professor Sidney D. Watson has regularly reported examples of health care injustice that should shock any conscience. *Id.* Professor Watson begins with stories of Mrs. Carolyn Payne, Infant Ysidro Aguinags and an unnamed Hispanic man. *Id.* However, Professor Watson, correctly points out that almost daily, one can find reports of such racial injustice in healthcare throughout the United States. *Id.*

[4] INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, UNEQUAL TREATMENT – CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 80-214 (2003) [hereinafter IOM].

[5] *See id.* (compiling over 100 studies from the last 10 years of racial and ethnic disparities). Note, however, that even larger literature reviews on this issue have been published by others. *See generally* Robert M. Mayberry, *Racial and Ethnic Differences in Access to Medical Care*, 75 MEDICAL CARE RES. & REV. 108 (2000); H. Jack Geiger. *Racial Stereotyping and Medicine: The Need for Cultural*

ordinary citizens can no longer ignore the fact that our nation focuses on the color of one's skin and the national origin of one's ancestors still largely determine the quality of health care a patient receives. This fact of continuing racial injustice is particularly shocking in an America that now imagines it long ago rid itself of overt racial discrimination and inequality.[6] Health disparities data confirm that we have not.

After controlling for differences among the races in socioeconomic status, health insurance, access to health care and geographic differences, the evidence still shows that Blacks and Latinos receive fewer and inferior clinical services than whites, irrespective of whether those services are for treatment of cardiovascular disease,[7] cancers,[8] mental illness,[9] pre-natal care[10] or HIV/AIDS.[11] Although African Americans, Latinos and Native Americans suffer and die from diabetes at significantly higher rates than do white Americans, studies reveal the disease is not adequately managed among minority patients.[12] Less is known about disparate care for those of Asian and Pacific Island descent, although the

---

Competence, 164 CANADIAN MED. ASS'N J. 1699 (2001); AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS. *Black-white disparities in Health Care*. 263 JAMA 2344 (1990).

[6] *See* Washington Post/Kaiser/ Harvard Racial Attitudes Survey, http://www.washingtonpost.com/wp-srv/nation/sidebars/polls/race071101.htm (indicating that 55% or white Americans polled believe minorities experience little or no discrimination). *See also* Jeffrey M. Jones, The Gallup Organization, Americans Hold Improving View of Race Relations in the U.S. (June 30, 2003), http://www.gallup.com/poll/content/login.aspx?ci=8725.

[7] *See* José J. Escarce et al. *Racial Differences in the Elderly's Use of Medical Procedures and Diagnostic Tests*, 83 AM. J. PUB. HEALTH 948, 950 (1993); A. Marshall McBean et al, *Differences by Race in the Rates of Procedures Performed in Hospitals for Medicare*, 15 HEALTH CARE FINANCING REVIEW 78 (Summer 1994). *But see* Nancy R. Kressin & Laura A. Petersen, *Racial Differences in the Use of Invasive Cardiovascular Procedures: Review of the Literature and Prescription for Future Research*, 135 ANN. INTERN. MED. 352, 363 (2001).

[8] *See generally* Peter B. Bach et al., *Survival of Blacks and Whites After a Cancer Diagnosis*, 287 JAMA 2106 (2002).

[9] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY 37 (2001).

[10] *See generally* Kate M. Brett et al., *Differences Between Black and White Women in the Use of Prenatal Care Technologies*, 170 AM. J. OBSTETRICS & GYNECOLOGY 41-46 (1994).

[11] *See generally* Martin F. Shapiro et al., *Variations in the Care of HIV-Infected Adults in the United States*, 281 JAMA 2305 (1999).

[12] *See* M. H. Chin et al., *Diabetes in the African-American Medicare Population: Morbidity, Quality of Care, and Resource Utilization*, 21 DIABETES CARE 1090, 1093 (1998).

incidence of several diseases such as Tuberculosis is inordinately high among this population of Americans.[13] Ironically, Black, Native - and Hispanic-American patients have *greater* access to some healthcare services than do whites – those un-desirable services such as amputations, orchiectomies[14] for prostate cancer,[15] and cesarean section deliveries.[16] These are undesirable but necessary services.[17] Undesirable means services a patient would have avoided if an alternative were available. For example, a man would prefer to keep his testicles if the disease they carry could be cured. A women would likely prefer to deliver vaginally if complications were not present. Any patient would prefer to keep a limb if it could be made healthy, instead of undergoing an amputation. Undeniably, eliminating these disparities will require the work of social scientists,[18] health care providers,[19] politicians,[20] environmentalists,[21] clergy,[22] patients[23] and

---

[13] *See* Centers for Disease Control, *Racial/Ethnic Health Disparities Fact Sheet*, http://www.cdc.gov/od/oc/media/pressrel/fs040402.htm (last visited August 2005) (providing a discussion of Tuberculosis prevalence by race).

[14] Surgical removal of the testicles.

[15] Gerald E. Thompson, *Discrimination in Health Care*, 126 ANNALS OF INTERNAL MEDICINE 910, 911 (1997).

[16] *See* David C. Aron et al., *Variations in Risk-Adjusted Cesarean Delivery Rates According to Race and Health Insurance*, 38 MEDICAL CARE 35, 35 (2000). *See also* P. Braveman et al., *Racial/ethnic differences in the likelihood of cesarean delivery, California*, 85 AM. J. PUBLIC HEALTH 625, 628 (1995).

[17] "Undesirable" services are medical treatments that patients would prefer not to receive. Amputations, for example, are last resort solutions that most patients would prefer to avoid. *See* Aron, *supra* note 16, at 35. *See also* Braveman, *supra* note 16, at 628.

[18] *See generally* NATIONAL INSTITUTES OF HEALTH OFFICE OF BEHAVIORAL AND SOCIAL SCIENCE RESEARCH, STRATEGIC PLAN FOR HEALTH DISPARITIES RESEARCH, FY 2002-2006, http://obssr.od.nih.gov/Activities/HealthDisp.htm (last visited September 24, 2005).

[19] *See generally* NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE, FIVE YEAR PLAN ON MINORITY HEALTH DISPARITIES, *available at* http://www.ninds.nih.gov/about_ninds/plans/disparities.htm (last visited September 24, 2005). *See also* Diana J. Burgess et al., *Why do Providers Contribute to Health Care Disparities*, 19 J. GENERAL INTERNAL MEDICINE 6 (2004).

[20] *See generally* H.R. 2553, 108th Cong. (1st Session 2003) (to amend Public Health Service Act to award grants to treat diabetes in minority communities).

[21] *See generally* Ernie Hood, *Dwelling Disparities: How Poor Housing Leads to Poor Health*, 113 ENVIRONMENTAL HEALTH PERSPECTIVES A311 (2005), *available at* http://www.yubanet.com/artman/publish/article_20418.shtml.

[22] *See* American Health Quality Association, *QIO's Faith-Based Initiatives at* http://www.ahqa.org/pub/media/159_766_3850.cfm. *See also* Agency for Healthcare Research and Quality, *Church Attendance May Serve as an Additional Health Safety*

many others to comprehensively address the issue. Although the problem is multi-faceted, this paper focuses on legal solutions. A core goal of the Civil Rights movement was to use the law as a tool to address and eradicate inequality and injustice. Although several Civil Rights Laws proved useful in this effort,[24] this article focuses specifically upon Title VI of the Civil Rights Act of 1964. Title VI was motivated in large part by the need to address segregation in health care institutions.[25] Early civil rights litigation and the use of Title VI law were successful in desegregating hospital emergency departments, patient wards and medical staffs. Advocates were able to skillfully use the Civil Rights law to bring down the "Whites Only" signs in hospital and medical clinic waiting rooms without having to confront the violent marches, fire hoses and police dogs that were needed to desegregate lunch counters and schools. Yet, these early victories in health care civil rights litigation now stand in stark contrast to the helpless state of American Civil Rights Law as applied to health care discrimination.

Today, Title VI, the very Civil Rights law that was designed in large part to eliminate racial injustice in hospitals, has proved singularly ineffective in addressing certain well-known forms of persistent health care inequalities. Legal scholars have documented the ineffectiveness of the Department of Health and Human Services' (DHHS) Office of Civil Rights (OCR) and made recommendations for changes to the administrative enforcement of Title VI.[26] Still others

---

Net for Impoverished Black Communities, *available at* http://www.ahcpr.gov/research/feb04/0204RA11.htm.

[23] *See* American Psychological Association, *Support for Behavioral and Social Science Research To Eliminate Health Disparities* (June 2004), *available at* http://www.apa.org/ppo/issues/behhlthdisparity.html (Last visited August 2005).

[24] Prior to the landmark legislation popularly called the Civil Rights Act of 1964, Congress enacted two other major Civil Rights laws. Moreover, the Civil Rights Act contains provisions other than Title VI to provide redress for discriminatory conduct. These include 42 U.S.C. §§ 1981, 1983 and 1985 as well as Title VII which addresses employment discrimination particularly. All these statutes are outside the scope of this paper except as they have impact on Title VI litigation and enforcement.

[25] *See* DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION (1999) (providing an accessible history of the passage of Title VI and its relation to the grass roots effort to address hospital segregation see chapter six).

[26] *See* Louise G. Trubeck, *Achieving Equality: Healthcare Governance in Transition*, 7 DEPAUL J. HEALTH CARE L. 245, 248 (2004) (OCR has hardly developed its Title VI enforcement program since 1980); Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 YALE J. HEALTH POL'Y., L. & ETHICS 215, 246 (2003) (enlarge the spending authority of OCR and cross-agency commitment to civil rights). *See also* Rene Bowser, *Racial Bias in*

have suggested ways in which the Civil Rights laws might be changed or re-written to do a better job of attacking health care injustice.[27] Owing much to the scholarship that has proposed such incremental changes in Civil Rights Law and its enforcement procedures, this article suggests a somewhat more radical approach. It outlines a way to use American Civil Rights legislation as currently written to bring a new form of action to combat the racial discrimination that plagues our health care system. This article advances a strategy that reestablishes a private individual's right to bring a disparate impact claim under Title VI, despite the United States Supreme Court's holding in *Alexander v. Sandoval* prohibiting these private causes of action, by initiating Title VI litigation *collaterally* under the Federal Civil False Claims Act (FCA).[28]

Part I of this article begins with a brief overview of Title VI of the Civil Rights Act and its enabling regulations. It includes a survey of this law's application to the health care industry to provide an outline of the elements of a successful Title VI action, gleaned from close analysis of the features of Title VI cases that have succeeded. This section provides the basis for pleading a sound Title VI claim which is the underlying pre-requisite to pursing the new strategy proposed in this paper. Part II describes a new strategy to use Title VI: Title VI claims should be brought against providers and other defendants by alleging these Civil Rights violators have defrauded the United States Government in violation of the Civil False Claims Act. This section begins with an overview of the Civil False Claims Act, an anti-fraud statute that is being used elsewhere to create private causes of action where, as in health care, the Government has failed to enforce the laws as written. Because that statute is subject to abuse and over

---

Medical Treatment, 105 DICK. L. REV. 365, 382 (2001) (OCR must take its enforcement obligations seriously); Daniel K. Hampton, *Title VI Challenges by Private Parties to the Location of Health Care Facilities: Toward a Just and Effective Action*, 37 B.C. L. REV. 517, 524 (1996) (citing commentator who says under Reagan and Bush administrations, OCR virtually abdicated its Title VI health care monitoring and enforcement responsibilities).

[27] *See* Joel Teitelbaum & Sara Rosenbaum, *Medical Care as a Public Accommodation: Moving the Discussion to Race*, 29 AM. J. OF LAW AND MEDICINE 381, 383 (2003) (recommending extension of public accommodation definition to include private health providers as under ADA). *See also* Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination – It Shouldn't Be So Easy*, 58 FORDHAM L. REV. 939 (1990) ("unhitch" possible Title VI defenses from the standards set under Title VII law to make adverse impact cases more difficult to defend).

[28] 31 U.S.C. §3729.

use as an enforcement mechanism, Part II also contains a checklist of areas appropriate for FCA enforcement that distinguish the Title VI application from others less well suited to fraud prosecution. Finally, Part II sets out a litigation strategy using the FCA to mount a campaign against health care discrimination by providers, and ineffective enforcement of Civil Rights Laws by the government. Part III ends with brief concluding observations.

I. THE RISE AND FALL OF TITLE VI LITIGATION IN HEALTH CARE

The approach to Civil Rights litigation recommended in this paper begins with an allegation that the underlying laws against discrimination have been violated. Therefore, it is important to consider the provisions and limitations of those underlying laws that have been used historically to fight racial inequality in healthcare. This section accomplishes this by providing a chronological review of civil rights cases in health care during three successive periods. The first group of cases, litigated during the period from Reconstruction to 1964, rest primarily on allegations that racial injustice in healthcare violated the United States Constitution. The second group of cases arose after passage of the Civil Rights Act of 1964 when Title VI became the most effective weapon of choice wielded against some forms of discrimination. This statute and others leveraged the Congressional spending power to accomplish desegregation of health care facilities. Finally, the Post Civil Rights Era cases constitute a third category of Title VI litigation. These later cases reveal timid judicial interpretations of Title VI and a marked weakening in the administrative enforcement of that law. The purpose of the chronological review undertaken here is not just to recall history, but rather to understand principles and strategies that have worked in the past, and to discern practical ways to use them in future legal assaults on the inequality in health care delivery that persists to date. Most importantly, this section concludes that Civil Rights activists desperately need a new strategy to address racial and ethnic disparities in health care.

A. Segregation in American Healthcare – An Historical Overview

Almost as long as there have been hospitals in America, there has been racial discrimination in health care. The first hospital founded in the

United States was the Pennsylvania General Hospital, founded in Philadelphia in 1751 from private funds, donated for the care of the poor and the insane. In the beginning of its operations, records from Pennsylvania General did not show that any patients other than whites were admitted for care. The institution was, in fact called the "First Anglo Hospital" in the United States. However, historical records allow us to surmise that the institution eventually began to admit non-Caucasian patients. Beginning in 1825 and 1829 respectively, Pennsylvania General began to record the "color" and "national origin" of admitted patients, confirming that the hospital at some point began offering services to both Black and white patients.[29] In fact, prior to the end of slavery in America, the judicial record conveys that African-Americans received a considerable amount of quality medical attention whenever needed; their health influenced their monetary value as property of slave-owners.[30] After the Civil War, providing access to medical care for African Americans took on different implications. Waves of Blacks migrating from the south began to place pressure on health care institutions to serve Black and white patients alike. During Reconstruction, racial segregation, emerged both within hospitals shared by African-American and white patients, nurses and physicians, and in the structure of the hospital industry itself. For example, in 1917, Harlem Hospital in New York City hired several Black nurses and immediately thereafter, several white nurses resigned. Similarly, when Dr. Louis T Wright was appointed a clinical assistant in the outpatient department, four white physicians resigned. Dr. Lois Wright is credited with introducing an intradermal vaccination for smallpox. He graduated from the Harvard Medical School in 1915, went on to serve in the Army Medical Corps during WWI, and was a strong advocate and outspoken leader of fully integrated, publicly funded hospitals. Dr. Wright became the medical director at Harlem Hospital

[29] *See* SMITH, *supra* note 24, at 199. Pennsylvania General was unique in its affiliation with the University of Pennsylvania in that it also provided residency training for Black physicians, admitting its first African American resident in 1947.

[30] *See* Wilson v. Shackelford, 4 Rand. 5, 25 Va. 5 (1826) (female slave examined by "many medical gentlemen" to determine whether health was sound); Belfour v. Raney, 8 Ark. 749, 3 Eng. 479 (1848) (slave's mother, though owned by different master, called for physician who attended her son's illness and therefore physician's fee owed); Wilkinson v. Mosely, 18 Ala. 812 (1850) (action to recover value of Negro girl hired to defendant who breached his promise to treat her carefully and hire physician to attend to her in sickness); Murphy v. Mutual Benefit Life & Fire Ins., 6 La. Ann. 518 (1851) (suit on life insurance policy on Negro slave who was attended "daily" by physicians prior to sale and declared to be in good health).

in 1938 and was responsible for leadership in both the public and scientific arena until his death in 1952.

For example, in his excellent book, *Health Care Divided*, David Barton Smith chronicles the history of Black-owned and operated hospitals in America. As Jim Crow emerged, African American communities built their own hospitals to treat patients excluded from white institutions. In 1862, the Federal Government provided funds to the Freedman's Bureau to establish the Freedman's Hospital (now Howard University Hospital) in Washington, D.C. to treat newly freed slaves. Hospitals and medical schools all over the nation from cities such as Chicago's Provident Hospital and Training School for Nurses (1891);[31] Mercy-Douglas Hospital in Philadelphia (1895); Dunbar Memorial Hospital in Detroit (1918); Lincoln Hospital (1901) in Durham, North Carolina were opened to train Black nurses and physicians,[32] and to treat their patients excluded from white institutions. Similar institutions arose to serve other ethnic minorities as well. For instance, in 1852, the Mt. Sinai Hospital opened in New York City to serve the growing Jewish immigrant community not welcome at other New York hospitals. Mt. Sinai purchased its first x-ray machine in 1900 and located it in the same synagogue that housed its operating room when religious services were not in session. By World War I, health care in America was offered on a wholly segregated basis. Thus, early Civil Rights cases were aimed at attacking and dismantling segregation.

B. The Early Health Care Civil Rights Cases: Reconstruction To 1964

In 1948, the first reported Civil Rights case against a hospital, a New York Court acknowledged that the Civil Rights Laws of New York State effectively prohibited the defendant hospital from denying the

---

[31] *See* Black History Month: A Medical Perspective, http://www.mclibrary.duke.edu/hmc/exhibits/blkhist. The first black-owned hospital in the United States, founded by Dr. Daniel Hale Williams, also founder of the National Medical Association which remains the professional society for Black physicians. *Id.*

[32] *See generally* Howard University College of Medicine, http://www.med.howard.edu/about_hucm.htm. Howard Medical School was opened in Washington, D.C. in 1868 and Meharry Medical College was established in Tennessee in 1876. *Id.* Both trained Black and white physicians and remain, to this day, preeminent institutions for the training of African American physicians and health professionals. *Id.*

plaintiff's admission on account of "race, creed or color".[33] Racial exclusion, however, was not the crux of this early case. Rather, in *Zlotowitz v. Jewish Hospital*[34] the plaintiff, a Jewish rabbi, unsuccessfully charged the defendant hospital with violating his First and Fourteenth Amendment rights to freely exercise his faith. Jewish Hospital refused to permit Rabbi Zlotowitz to perform circumcisions on babies born in the hospital, though the Rabbi claimed he was qualified under Hebrew law to do so. The *Zlotowitz* Court held that because Jewish Hospital was private, its decision to disallow Rabbi Zlotowitz's practice was not state action. Therefore, Jewish Hospital was outside the reach of state and federal constitutional law.

Ten years later, a North Carolina case similarly focused on the private status of a defendant hospital to resist another plaintiff's effort to desegregate a hospital. In *Eaton v. Board of Managers of the James Walker Memorial Hospital,* three Black physicians charged that the defendant hospital had denied them courtesy staff privileges solely on the basis of their race and color, in violation of §§ 1981 and 1983 of the Civil Rights Laws and in violation of the equal protection clause of the Constitution's Fourteenth Amendment of the United States.[35] Although the defendant James Walker Memorial Hospital had been established on public land, by the time Dr. Eaton brought suit, the property was no longer owned by the City and County. Therefore, the hospital's operations were not the actions of the state and consequently were not within the reach of the Constitution. The defendant hospital became "private" in 1901, after receiving a sizeable gift from a private donor to renovate and relocate the hospital. To accomplish the new private status, the hospital's City managers conveyed the public land beneath the relocated hospital to a trust,[36] and then chartered the hospital as a private corporation.[37] The City managers accomplished this conveyance, declaring "it was desirable that the management of the hospital be removed as far as possible from the control of local municipal authorities, subject to changing political conditions, and to that end charted the hospital as a body corporate."[38] The *Eaton* case,

[33] Zlotowitz v. Jewish Hospital, 193 Misc. 124, 126, 84 N.Y.S. 61, 63 (N.Y. Sup. Ct. 1948).
[34] *Id.*
[35] Eaton v. Board of Managers of James Walker Memorial Hospital, 261 F.2d 521, 522. *See* 42 U.S.C.A. §§ 1981, 1983.
[36] With a *reverter* to the City and County in the case of abandonment. *See Eaton*, 261 F.2d at 522.
[37] To be operated by the *same* Board of Managers as before the conveyance.
[38] *Id.* at 522.

teaches, therefore, that privatization was one way hospitals managed to avoid the reach of the early Civil Rights Laws and of the Constitution's equal protection clause.

A state-owned mental institution in *Johnson v. Crawfis* used another avoidance approach.[39] There, an African-American minor sought declaratory and injunctive relief for the defendant hospital's refusal to admit him because he was a Negro. The *Johnson* court dismissed this case, rejecting the plaintiff's claims that the hospital had violated the due process and equal protection clauses of the Constitution or the laws of the United States. According to the *Johnson* Court, the plaintiff had been denied admission because he was merely mentally defective, rather than suffering from psychosis that required hospitalization. Moreover, the hospital explained, the plaintiff minor was denied admission because there were no available beds for Negro patients specifically. According to the Arkansas court in *Johnson*, this explanation showed the defendant hospital did not exclude the plaintiff because of his race alone. Since the defendant hospital's Superintendent could properly exercise his discretion not to accept patients beyond the hospital's capacity, no unconstitutional discrimination had occurred.[40] Pointing to the fact that Negro patients were regularly admitted into the defendant hospital, the *Johnson* Court declined to find the exclusion in this case was based on race. The *Johnson* Court acknowledged that the plaintiff also raised the question of whether the defendant's system of segregating patients by race was, indeed permissible under the U.S. Constitution. The *Johnson* Court declined to reach this issue, finding that the plaintiff did not properly bring the issue of segregation before the court in his Complaint.[41] Arguments based on the equal protection clause alone, were ineffective to combat racial segregation in American hospitals by the middle of the Twentieth Century.

A new litigation approach emerged by the close of World War II. The United States Congress became a full participant in establishing *de jure,* segregated health care, with the passage of the Hill-Burton Act in 1946. Enacted as part of the Public Health Service Act, the "Hospital Survey and Construction Act" ("Hill-Burton Act" for short) required hospitals using federal funds for construction and renovation to meet two conditions: first, they had to provide a "reasonable volume" of indigent care and second, hospitals had to do so on a non-

---

[39] Johnson v. Crawfis, 128 F.Supp. 230 (E.D. Ark. 1955).
[40] *Id*. at 234.
[41] *Id*. at 239.

discriminatory basis as part of their community service.[42] However, when the Hill-Burton Act passed, it was modified by a regulation which qualified the non-discrimination or "community service" and "reasonable volume" preconditions to the receipt of federal construction funds with the language of the following explicitly discriminatory exception:

> [B]ut an exception shall be made in cases where *separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group.*"[43]

Thus, the federal statute that provided federal dollars to build and expand hospitals, also codified the doctrine that ensured the public funds would be spent on separate and unequal hospital and health care throughout the nation. This statutorily-sanctioned, and federally-funded segregation persisted from 1946 until November 1, 1963 when the Fourth Circuit Court of Appeals declared the discriminatory separate but equal language of the Hill Burton Act un-Constitutional in the watershed case, *Simkins v. Moses H. Cone Memorial Hospital*.[44]

The *Simkins* case was brought by six African-American physicians, three African-American dentists and two African-American patients who sued collectively to raise not only Fifth and Fourteenth Amendment challenges to the Constitutionality of the two defendant hospitals' segregation policies,[45] but also to challenge the U.S. Congress' exercise of its spending power under the Hill-Burton Act. After reviewing the substantial appropriations each defendant hospital had received for construction and renovation under the Hill-Burton Act, and the way in which the statute's separate-but-equal exception operated, the *Simkins* Court effectively reversed the earlier *Eaton* case,[46] and put to rest the question of whether these hospitals

[42] 42 U.S.C.A. §291 (c)(e)(2). This is the statute that contains the "reasonable volume" requirement.

[43] *See* 42 C.F.R. §53.112. This is the regulation that describes what hospitals must do to meet the "reasonable volume" requirement.

[44] Simkins v. Moses H. Cone Memorial Hospital, 323 F.2d 959, 969 (4th Cir. 1963).

[45] Simkins, 323 F.2d at 960-61. The Simkins case challenged staffing and admissions procedures at the Long Hospital and the Cone Hospital, two non-profit hospitals, both located in Greensboro, North Carolina.

[46] *Id*. at 970. Importantly, after losing his first case challenging segregation at the James Walker Memorial Hospital, Dr. Hubert A. Eaton filed a second action,

participating in the Hill-Burton program engaged in state action by stating:

> Here, the most significant contacts compel the conclusion that the necessary 'degree of state (in the broad sense, including federal) participation and involvement' is present as a result of the participation by the defendants in the hill-Burton program. The massive use of public funds and extensive state-federal sharing in the common plan are all relevant factors. . . . But we emphasize that this is not merely a controversy over a sum of money. Viewed from the plaintiffs' standpoint it is an effort by a group of citizens to escape the consequences of discrimination in a concern touching health and life itself. As the case affects the defendants it raises the question of whether they may escape constitutional responsibilities for the equal treatment of citizens, arising from participation in a joint federal and state program allocating aid to hospital facilities throughout the state. . . . Our concern is with the Hill-Burton program, and examination of its functioning leads to the conclusion that we have state action here. . . . Such involvement in discriminatory action 'it was the design of the Fourteenth Amendment to condemn.'[47]

The *Simkins* Court concluded that the separate but equal provisions of Hill-Burton were flatly unconstitutional under both the Due Process clause of the Fifth Amendment, and the Equal Protection Clause of the Fourteenth Amendment.

David Barton Smith recalls the impact the *Simkins* decision had on the debate that had been taking place in Congress on proposed legislation that would later become Title VI of the Civil Rights Act of

---

challenging the same discriminatory procedures, this time basing the challenge on the state's extensive involvement in that hospital's operations as outlined in the Simkins decision. In the second case, relying upon Simkins and the Supreme Court's new view of 'state action" as expressed in Burton v. Wilmington Parking Authority, 365 U.S. 715, 726 (1961), Dr. Eaton prevailed and the Fourth Circuit held James Walker Memorial Hospital's conduct involved state action and was indeed subject to the Fifth and Fourteenth Amendments). *See* Eaton v. Grubbs, 329 F.2d 710, 715 (4th Cir. 1964).

[47] *Simkins*, 323 F.2d at 967-968.

1964.[48] In March 1964, the United States Supreme Court denied *certiorari* to defendant hospitals' appeal of the Fourth Circuit's *Simkins* decision,[49] Congress recognized this denial of certiorari as a clear signal that the United States Supreme Court also viewed the 'separate but equal' doctrine as unconstitutional. This gave the federal legislature the final impetus to pass the Civil Rights Act and legislatively dismantle the now discredited 'separate but equal' doctrine under United States law.

These early civil rights cases are instructive in the effort to employ Civil Rights Law today. First, taken together, the two *Eaton* cases, *Johnson*, *Simkins* and *Zlotowitz* demonstrate a progressively increased focus on the issue that initially appeared to be the core strength of segregationist hospitals' defenses against constitutional challenges: the absence of state action. After losing the early civil rights cases on this basis, the civil rights litigants returned to court repeatedly with new arguments designed to address the issue that had spelled defeat in earlier cases. Second, the litigants employed lessons from cases outside the hospital context. In *Simkins*, the *Burton v. Wilmington Parking Authority* case provided focus on government owned land to draw the analogy between state involvement in the context of a privately owned restaurant and in hospital operations. Third, the collective leadership of minority professionals was most effective when physicians and dentists sued not only to vindicate their own interests but united with patients to address discrimination against them as well. Finally, these early cases were ultimately successful because the targeted injustice was clear: all civil rights litigation was aimed at eliminating segregation in hospitals. The cases focused on the inequality that arose because hospitals treated minority and majority citizens separately. To be sure, some of the success that resulted from this line of cases was due to changing morals and views. Tolerance for health care discrimination was weakening as evinced by litigants challenging discrimination on state law grounds that previously would have failed.[50] Even the advantage of changing attitudes towards

---

[48] *See* SMITH, *supra* note 24 at 101 (providing references to Congressional Record entries by Senators Jacob Javits and Kenneth Keating).

[49] Moses H Cone Memorial Hospital v. Simkins, 376 U.S. 938 (1964).

[50] *See* Washington v. Blampin, 226 C.A.2d 604, 606, 38 Cal. Rptr. 235 (1964) (holding state law prohibition against discrimination by 'business establishments' applies also to physicians). *See also* Arnett v. Seattle General Hospital, 65 Wash.2d 22, 395 P.2d 503, 507 (1964) (affirming State Board's decision to require hospital to accept employment application of Black applicant and offer first vacant job to her to rectify discriminatory employment practice).

discrimination may be used in litigation today.[51] If Civil Rights law is to be used effectively once again in health care litigation, litigants must 1) learn from the unsuccessful cases by refining legal arguments to focus subsequent arguments on the areas of weakness revealed in previous litigation; 2) draw analogies from cases outside the precise area of hospital sponsored discrimination; 3) identify collaborative plaintiff constituencies; and 4) above all, work to precisely identify the discriminatory conduct under attack. These lessons are relevant for direct attacks on racial disparity under the Civil Rights laws, and for the collateral litigation approach proposed in this paper; in both cases, the fundamental strength of the core allegations will contribute to the overall success of the litigation strategy.

C. The Civil Rights Era: Extending the Legacy of Simkins and Title VI

The success of the *Simkins* case and its progeny[52] turned on the finding that federal spending provided the requisite state action to compel compliance with the Constitution. The passage of the Medicare and Medicaid Acts infused the American health care system with taxpayer dollars to purchase health care for America's elderly, disabled and poor citizens. Thus, spending power of the federal government provided ample leverage to attack overtly discriminatory system-level practices.

In *Cypress v. Newport News General Hospital*,[53] a Black physician brought a class action suit on behalf of himself and his patients, in order to successfully challenge the exclusion of Black physicians from the defendant hospital's medical staff. The *Cypress* Court enjoined the private hospital's discriminatory behavior based on the state's investment of federal Hill-Burton funds. Despite questions concerning the plaintiff's class standing raised in *Coleman v. Humphreys County Memorial Hospital*,[54] the Mississippi District Court in that case enjoined "discriminatory practices" in a public facility citing the defendant County Hospital's receipt of Hill-Burton funds in that case. But success of the *Simkins* arguments did not end with cases involving federal or state funded institutions. The *Simkins* case made

---

[51] *See* Endorsing the Concept, http://www.righttohealthcare.org/Simply.htm.
[52] *See infra tbl.* 1 (providing a listing of Civil Rights cases brought to enforce Title VI against health care providers since *Simkins*).
[53] Cypress v. Newport News General and Nonsectarian Hospital Ass'n, 375 F.2d 648, 651 (4th Cir. 1967).
[54] Coleman v. Humphreys County Memorial Hospital, 55 F.R.D. 507, 509 (N.D. Miss. 1972).

possible the enactment of Title VI and gave birth to a tool of unprecedented potency for fighting racial segregation in hospitals and health care institutions.

1. Title VI – The Anti-Segregation Weapon of Choice

Title VI provides that ""[n]o person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[55] Historically, the statute has been interpreted to offer plaintiffs two alternate methods of proving this statute has been violated. The plain language of the statute provides a "disparate treatment" claim under which a plaintiff alleges the defendant violated Title VI by treating the plaintiff differently from other similarly situated individuals. The disparate treatment claim requires a plaintiff to first prove that the defendant discriminated against her on a prohibited basis, in violation of the statute. After the plaintiff makes this *prima facie* showing of discrimination, the defendant may rebut this evidence by offering any legitimate reason for the allegedly discriminatory practice. Upon this showing by the defendant, the burden shifts to the plaintiff who must then prove the defendant's proffer of a legitimate reason was merely pretext for racial discrimination. In short, the plaintiff must show the defendant's specific intent was to discriminate. While plaintiffs can prove intent with circumstantial evidence including statistical data, the fact remains that evidence of discriminatory intent is difficult to adduce.[56] Therefore, plaintiffs have long favored the second type of claim available[57] under Title VI: the disparate impact cause of action.

A plaintiff pleading a disparate impact claim under Title VI faces similar burden-shifting requirements as the disparate treatment plaintiff. First, the plaintiff must discharge its burden to make out a *prima facie* case of discrimination. This may be based upon statistical evidence that a practice or policy has had a disproportionately negative discriminatory impact. Some courts have reasoned that there is a statistical threshold sufficient to support a claim of adverse impact

---

[55] Title VII §601, 42 U.S.C. §2000d.
[56] *See* HAROLD S. LEWIS, JR. & ELIZABETH J. NORMAN, CIVIL RIGHTS LAW AND PRACTICE §3.9, at 313 (2nd ed. 2004).
[57] *See infra* Part I.D.1 (providing a discussion of Alexander v. Sandoval and the Supreme Court's limitations now placed on disparate impact claims under Title VI).

under Title VI.[58] Other courts have held that a statistical showing alone is insufficient to establish a disparate impact claim.[59] Once the plaintiff has made a *prima facie* case of discrimination, the defendant must show a legitimate goal is served by the allegedly discriminatory practice. Then the burden returns to the plaintiff to show that a less discriminatory alternative is plausibly available to the defendant.[60]

Title VI litigation enjoyed a period of success following the passage of that statute, in cases where the focus became eliminating segregation and discrimination, rather than questioning the state's financial involvement.[61] In *Marable v. Alabama Mental Health*

---

[58] Courts and litigants can gain insight concerning the quantum and quality of statistical proof required to make out a *prima facie* case by reviewing disparate impact cases brought successfully under Title VII and the Age Discrimination in Employment Act (ADEA). In Dothard v. Rawlinson, 433 U.S. 321 (1997), the Supreme Court found a state's facially neutral height and weight requirement for prison guards had a disproportionate impact on women in violation of Title VII. The disparate impact of these physical standards was demonstrated by the plaintiff's statistical evidence showing a gross disparity in the rate that women and men were hired. The state's standards excluded over 40% of the entire female population while excluding less than 1% of the male population from eligibility. In Berkman v. New York, 536 F.Supp. 177, 205-06 (E.D.N.Y. 1982), the court found a small statistical sample that showed an overwhelming statistical imbalance between the number of women and men passing physical exams for firefighter jobs was sufficient. There zero percent of women passed while 46% of men passed. In Leftwich v. Harris-Stowe State College , 702 F.2d 686, 690-93 (8th Cir. 1986), the plaintiff professor prevailed in a challenge to the defendant college's plan to reduce the number of tenured full time faculty members. The court found the exact correlation between tenureship and the protected class to be compelling. Expert testimony showed the mean age of non-tenured faculty was 34.3 years but the mean age of tenured faculty was 45.8 years. Therefore, a plan reserving positions for non-tenured faculty but eliminating tenured professors had an adverse impact on people over 40 years old, a protected class under the ADEA. *But see* Smith v. City of Jackson Mississippi, 125 S.Ct 1536. 1546 (2005) (where Supreme Court found plaintiffs failed to identify specific employment practice was discriminatory thus numerical disparities insufficient to prove violation of the ADEA).

[59] *See* United States v. Virginia, 454 F.Supp. 1077, 1086 (E.D. Va. 1978) (the court considered not only the statistical evidence that height and weight requirements for State Trooper applicants disqualified more than 98% of all women and only 50% of all men, but also the evidence that Virginia had never hired a woman state trooper to conclude the "inexorable zero" established a disparate impact case under Title VI. 42 U.S.C. §2000e-2(a)).

[60] *See* Guardians Ass'n. v. Civil Service Commission of New York City, 463 U.S. 582, 593, 607 (1983) (holding that even without showing discriminatory intent, proof of discriminatory effect was sufficient to establish a Title VI violation.)

[61] In fact, it is noteworthy that the successful focus on state funding that worked to address racial discrimination by hospitals in *Simkins*, did not translate into similar

Board,[62] for example, patients won their challenge to end segregation and employment discrimination in mental health facilities based solely on the Title VI non-discrimination provision and on the Equal Protection clause of the United States Constitution. However, efforts to extend the anti-discrimination provisions of Title VI beyond hospital conduct involving either the denial of staff privileges to minority physicians, denial of admission privileges to minority patients, or overtly segregated facilities have been met with little success.[63] Ten years elapsed between the successful enforcement of Title VI in *Cypress*, *Coleman* and *Marabel* and the following case discussed below in which a plaintiff prevailed under Title VI in an action against a hospital defendant.

D. The Post Civil Rights Era – Lessons in Victory and in Defeat

The next phase of modern Title VI victories came in three categories. Although not all staff privileging cases have been successful, several cases involved litigation contesting discrimination against minority physicians. Another successful case raised a challenge to discrimination against a minority patient. However, the most instructive of the Post Civil Rights cases involved a successful challenge to the impact of a state's discriminatory policies against Medicaid patients generally.

---

success in later litigation attempting to address hospitals' discrimination against the indigent on the same basis. In Cook v. Ochsner, 559 F.2d 968, 973-74 (5th Cir. 1977), a class action suit failed to compel hospitals receiving Hill-Burton funding to treat all indigent patients where the Court found presumptive compliance with Hill Burton's reasonable volume requirement. Also, the success of cases alleging racial discrimination based on the Constitution and Title VI, did not necessarily imply success in litigation alleging discrimination against the poor. *See* Simon v. Eastern Kentucky Welfare Rights Organization, 426 U.S. 26, 37 (1976) (Supreme Court declined to find error in an IRS ruling that granted tax exempt status to a non-profit hospital that denied care to indigent patients).

[62] 297 F.Supp. 291, 298 (M.D. Ala 1969).

[63] Notably, a series of Title VI cases challenging the disparate impact on minority communities when hospitals relocated from urban centers to suburbia, failed. *See* Jackson v. Conway, 476 F.Supp. 896 (E.D. Mo. 1979) (holding that plaintiffs must exhaust administrative remedies before filing under Title VI); National Association for Advancement of Colored People v. Medical Center, Inc., 599 F.2d 1247 (3rd Cir. 1979); Bryan v. Koch, 627 F.2d 612 (2nd Cir. 1980); United States v. Bexar County, 484 F.Supp. 855 (D.C. Tex. 1980). *See infra* Part III.D (providing a discussion of these cases).

In *Chowdhury v. Reading Hospital and Medical Center*,[64] a physician who was "not of the Caucasian race" alleged racial discrimination when the defendant hospital declined to extend staff courtesy privileges. The Third Circuit Court of Appeals held in *Chowdhury* that the plaintiff did not have to exhaust administrative procedures before bringing a private action seeking injunctive relief for disparate treatment under Title VI.[65] After another ten years, in 1992, the United States Department of Health and Human Services (HHS) won a qualified victory in a case raising similar staff privileges issues on an institutional, not individual basis. In *United States v. Harris Methodist Fort Worth*,[66] HHS sought to execute a search of the defendant hospital's peer review and credentialing records as part of an investigation of the hospital's compliance with Title VI. The Fifth Circuit held that Title VI's broad prohibition against discrimination indeed applies to forbid hospitals from discriminating against physicians in staff privileges decisions. However, the Court also held the scope of the HHS investigation and records search was limited by the Fourth Amendment of the United States Constitution.[67] The *Harris Methodist* and *Chowdhury* cases are important because they permit Civil Rights law to be applied to fight discrimination against minority physicians who must play a crucial role in order to succeed in the fight against unequal and unjust health care delivery. A third staff privileging case from the Sixth Circuit[68] adds further breadth to the Title VI protections against physician staffing discrimination.

In *Fobbs v. Holy Cross Health System,*[69] an African-American specialist in obstetrics, gynecology and perinatology alleged that summary suspension of his privileges to perform intra-abdominal laser surgery violated Title VI. Moreover, Dr. Fobbs alleged that the discrimination he suffered also disadvantaged his patients—the intended beneficiaries of Medicare and Medicare funding -- on the basis of race.[70] The Third Circuit Court of Appeals reversed dismissal of Dr. Fobbs' Title VI claim, holding that the physician was not required to plead he was the intended beneficiary of the federally funded hospital program in order to state a claim for disparate

---

[64] Chowdhury v. Reading Hospital and Medical Center, 677 F.2d 317 (3rd Cir. 1982)
[65] *Id.* at 321.
[66] United States v. Harris Methodist Forth Worth, 970 F.2d 94, 96 (5th Cir. 1992).
[67] *Id.* at 99-100.
[68] Linton v. Comm'r of Health & Env't, Tennessee, 65 F.3d 508 (6th Cir. 1995) (holding nursing home bed certification policy violated Medicaid Act).
[69] Fobbs v. Holy Cross Health Sys. Corp., 29 F.3d 1439, 1442 (9th Cir. 1994).
[70] *Id.* at 1447- 48.

treatment.[71] The *Fobbs* Court was unsympathetic, however, to Dr. Fobbs' claim that he also represented his patients' interests as the incidental or third party beneficiary of federal funding on their behalf.[72] Dr.Fobbs' personal, disparate treatment claim survived summary judgment while the disparate impact claim he brought on behalf of his patients did not. The lesson for future Title VI litigants from the *Fobbs* case is that physicians, along with their patients must sue in order to state a disparate impact claim on their behalf, as litigants in the early civil rights cases such as *Cypress*, *Marable*, and *Coleman* demonstrated. This is the model that should be followed in future Title VI litigation.

In addition to the *Chowdhury*, *Harris Methodist* and *Fobbs* staff privileging cases, an immigrant patient prevailed in a Title VI case that did not involve physician privileging issues. In *Atakpa v. Perimeter OB-GYN Associates, P.C.* [73] the Northern District of Georgia considered a Title VI challenge to the HIV testing policy of an obstetrics and gynecology clinic in Atlanta, Georgia. Mrs. Esther Atakpa, an immigrant to the United States from Nigeria, alleged the defendant clinic discriminated against her on the basis of her national origin when it refused to provide pre-natal care to her unless she submitted to HIV testing. According to the plaintiff, Perimeter did not terminate treatment for non-African patients who refused HIV testing. Mrs. Atakpa alleged that this disparate treatment violated Title VI.[74] The reported case arose on the plaintiff's motion for summary judgment. After noting the plaintiff would have to show discriminatory intent to prevail on her disparate treatment claim,[75] the *Atakpa* Court found that the question of whether the plaintiff's treatment was terminated because she was Nigerian or because she was non-compliant presented a disputed fact issue.[76] Although Mrs. Atakpa lost her summary judgment motion in this case, the court clearly acknowledged that her claim was cognizable under Title VI.[77] For this reason, Mrs. Atakpa's case is an example of the continued viability of private causes of action alleging disparate treatment in violation of Title VI.

---

[71] *Id*. at 1447.
[72] *Fobbs*, 29 F.3d at 1450. *See also* Doe v. St. Joseph's Hosp., 788 F.2d 411, 420 (7th Cir. 1986) (holding Korean doctor whose hospital privileges were terminated was not intended beneficiary of federally funded program, therefore, his Title VI claim failed).
[73] Atakpa v. Perimeter OB-GYN Assoc., 912 F.Supp. 1566 (N.D. Ga. 1994).
[74] *Id*. at 1574.
[75] *See* Guardian Ass'n v. Civil Service Comm'n, 463 U.S. 582, 584 (1983).
[76] *Id*. at 1575.
[77] *Id*.

Perhaps the most instructive of the Post-Civil Rights Era cases is *Linton v. Comm'r of Health and Environment of Tennessee*;[78] *Linton* provides a template useful for the type of challenges this paper argues should now be lodged against discriminating health care providers as part of the "new strategy" advocated herein. *Linton* was a class action brought by minority Medicaid-eligible plaintiffs. The *Linton* plaintiffs challenged the limited bed certification policy used by Tennessee nursing homes. Tennessee's policy allowed nursing facilities to spot identify certain beds for Medicaid participation, while isolating other beds for private-pay patients.[79] In 1990, the Tennessee District Court found this policy violated the Medicaid Act and Title VI.

> The Court finds that the plaintiff has established by a preponderance of the evidence that the Tennessee Medicaid program does have a disparate and adverse impact on minorities. Because of the higher incidence of poverty in the black population, and the concomitant increased dependence on Medicaid, a policy limiting the amount of nursing home beds available to Medicaid patients will disproportionately affect blacks.
>
> Indeed, while blacks comprise 39.4 percent of the Medicaid population, they account for only 15.4 percent of those Medicaid patients who have been able to gain access to Medicaid-covered nursing home services. In addition, testimony indicates that the health status of blacks is generally poorer than that of whites, and their need for nursing home services is correspondingly greater. Finally, such discrimination has caused a "dual system" of long term care for the frail elderly: a statewide system of licensed nursing homes, 70 percent funded by the Medicaid program, serves whites; while blacks are relegated to substandard boarding homes which receive no Medicaid subsidies.[80]

The *Linton* Court then ordered the state to submit a plan to address the disparate impact issue. In July 1990, the District Court

[78] Linton v. Commissioner, 65 F.3d 508 (6th Cir. 1995).
[79] *Id*. at 511.
[80] Linton v. Carney, 779 F.Supp. 925, 932 (M.D. Tenn. 1990).

entered an order adopting the state's submission in its entirety.[81] After licensed nursing homes successfully petitioned to intervene, the plan was modified and again challenged in 1995.[82] The Sixth Circuit Court of Appeals declined the nursing homes' invitation to dismiss the plaintiffs' Title VI claims. The *Linton* Court refused to disturb the earlier District Court decision, holding that "Tennessee's policy of allowing Medicaid participating nursing homes to certify fewer than all available beds for Medicaid participation was contrary to federal law, created a disparate impact upon minority Medicaid patients, and violated federal statutory Medicaid Requirements."[83] The *Linton* case teaches at least three lessons to future Title VI litigants.

First, the *Linton* plaintiffs identified and attacked a precise policy that had disparate impact on minority patients. The limited bed policy provided a clear target for the averments of discrimination, rather than generalized claims of unfair treatment. Second, the plaintiffs provided clear statistical evidence to show the disparate impact they alleged. From the outset, the District Court knew the proportion of Blacks in Tennessee's Medicaid population; what percentages of Tennessee's participating nursing homes used the limited bed policy; and the percentage reduction in nursing home bed availability that resulted from the Tennessee policy. To the extent that the *Linton* Court wanted to speak in terms of the numerical significance or quantifiable impact of the limited bed policy including the number of beds that otherwise would have been available to Medicaid patients, the *Linton* litigants supplied that information. Third, beyond the numbers, the *Linton* litigants made their case about real, live, identifiable nursing home patients who suffered as a direct result of the limited bed policy. The District Court opinion included the story of Mrs. Belle Carney, an 89 year-old African American woman who suffered from Alzheimer's disease, who was denied a suitable nursing home placement because of her Medicaid status due to the limited bed policy. Because of the policy, Mrs. Carney's nursing home bed was repeatedly de-certified, forcing Mrs. Carney to move from one inadequate nursing home placement to another, until finally she required emergency hospitalization.[84] The true impact of the limited bed policy became real when the Sixth Circuit related the story of Mrs. Mildred Linton who

---

[81] Linton v. Commissioner, No. 3-87-0941, 1990 WL 180245, at *1 (M.D. Tenn. Jul. 5, 1990).
[82] *See generally Linton*, 65 F.3d at 508.
[83] *Linton*, 1990 WL 180245, at *1.
[84] *See Linton*, 779 F.Supp. at 928.

had to move from her home of four years because her bed in the Green Valley Health Care Center was de-certified under the Tennessee limited bed policy.[85] Future Title VI cases will more likely succeed if they include the 1) precisely targeted allegations of disparate impact; 2) supported by statistical evidence of the disparate impact alleged; and 3) demonstrated by detriment suffered in the lives of real people who are part of the plaintiff class. Beyond the practical lessons from *Linton*, the proposition for which this case stands is a beacon to guide future Civil Rights litigation aimed at addressing racial inequality in health care delivery. Significantly the Tennessee District Court's conclusion that the Tennessee limited bed policies violated Title VI was challenged twice at the District Court level and twice in the Sixth Circuit. Each time, the Title VI holding remained undisturbed. *Linton*, therefore, stands for the proposition that state policies which limit access to care for Medicaid patients, and thus have a demonstrably disparate impact on minority patients, violate Title VI of the Civil Rights Act of 1964.

The plaintiffs' success in *Linton*, *Fobbs*, and *Atakpka* must be viewed within the limitations of other recent defeats to civil rights claims brought against health care providers. A brief overview of those cases follows.

1. Lessons from Recent Civil Rights Defeats in Health Care

Despite large and significant changes brought about during these early phases of civil rights litigation and legislation, there have been three notable categories of cases in which plaintiffs asserting civil rights claims against health providers have not been met with success. Cases involving physician staff privileges, alleged discrimination against health care employees and challenges to hospital relocation or consolidation are helpful to gain an understanding in this area despite their mixed results.

a) Physician Staff Privileges and Employment Cases

Courts have not been uniform in their handling of staff privileging cases brought under Title VI. The *Chowdhury, Harris Methodist* and *Fobbs* cases discussed above must be compared to other staff privileges cases where courts have been generally dismissive of physician claims of discrimination under Title VI. The cases turn on the question of whether a physician is an intended beneficiary of Title VI protections. Where courts find there is no nexus between the allegedly

[85] *See Linton*, 65 F.3d at 511.

discriminatory practice and the use of federal funds, physician claims have failed.[86] To the extent that staff privileging cases are to succeed as a tool in the fight against racial disparity in health care, litigants will have to emphasize the basic premise that increasing representation of minority physicians in health care delivery is a crucial lynchpin in increasing access and decreasing discrimination against minority patients. In fact, "discrimination against [minority] doctors imports discrimination against their patients [who are] . . . the primary beneficiaries. . . ."[87] Put another way, "by extending staff privileges only to those physicians who traditionally do not accept minority, Medicaid or under-insured patients, an institution's staff privileging policy has the impact of restricting the [number] of minority patients who [may] utilize"[88] its facility.[89] Thus far, this argument has not been successfully advanced in Title VI cases. If it is to succeed in future cases, litigants will have to address the concern expressed in *Fobbs* when the court dismissed the third party beneficiary claims, asserting that "Dr. Fobbs has not explained why *he* rather than his patients should receive money damages for injury inflicted on his patients."

Physician staff privilege cases are to be distinguished from a small group of Title VI cases that universally fail. In cases where employees of health institutions attempt to file discrimination claims

---

[86] *See* Doe v. St Joseph's Hospital, 788 F.2d 411, 420 (7th Cir. 1986) (dismissing Korean-American doctor's Title VI claim. Although plaintiff alleged racial discrimination claim under 42 U.S.C. §1981, he failed to state a Title VI claim because no allegation physicians are intended beneficiaries of Title VI). *See* Vuciecevic v. MacNeal Mem'l Hosp., 572 F.Supp. 1424, 1430 (N.D. Ill. 1983) (dismissing Serbo-Yugoslavian doctor's Title VI claim for failing to state a cause of action where no "logical connection between use of federal funds and the practice toward which the agency action is directed"); Bhatt v. Uniontown Hosp., No. 83-2455, 1986 WL 30681, at *4 (W.D. Pa. Mar. 20, 1986) (dismissing MD's Title VI claim where no evidence that his failure to receive staff privileges affected primary beneficiaries of federal funding, and, therefore, no private cause of action existed); Vakharia v. Swedish Covenant Hosp., 824 F.Supp. 769, 777 (N.D. Ill. 1993) (dismissing Indian doctor's attempt to premise his 42 U.S.C. §1985 claim upon Title VI where physician is not the intended beneficiary of federal funds); Battle v. Jefferson Davis Mem'l Hosp., 451 F.Supp. 1015, 1027 (S.D. Miss 1976) (dismissing Title VI claim where doctor fabricated residency record and had history of mental health and drug abuse).

[87] *See* Fobbs v. Holy Cross Health Sys. Corp., 29 F.3d 1439, 1447-48 (9th Cir. 1994).

[88] *Id*. at 1448.

[89] *See generally* Cook v. Ochsner, 559 F.2d 968 (5th Cir. 1977) (advancing and settling this very claim, according to Professor Sidney Watson, who was involved in the case).

under Title VI,[90] Section 604 of that statute articulates an exception that proves fatal to this argument. Title VI does not authorize action "with respect to any employment practice of any employer, employment agency, or labor organization except when a primary objective of the federal financial assistance is to provide employment."[91] This "primary objective" exception makes the distinction between employee and non-employee physicians in staff privileging cases important. If physicians are employees of the health care defendant, then there is no colorable Title VI discrimination claim. However, where physicians are independent contractors, a Title VI claim may survive.

b) Medical Student Admission Cases

Closely related to physician privileging cases are cases involving students or applicants who fail to gain or retain admission to medical school and residency programs who have sued, claiming Title VI violations. These students claim that the admissions process has a discriminatory impact on the number of minority physicians who are available to provide equitable care for minority patients. These cases have been dismissed on both the merits and on procedural ground. In one instance, the Eighth Circuit held that Title VI permits recovery for disparate treatment in a case filed against a university and that the plaintiff's claim was not barred by the Constitution's Eleventh Amendment.[92] On their face, the medical school admission cases may appear to only represent individual plaintiffs' attempts to vindicate their personal failures. However, these causes of action may prove important if minority students are continually denied admissions to medical schools, increasing the shortage of minority physicians. In that case, the same arguments concerning disparate impact on minority patients that apply to physician staff privileging cases will apply here as well.

c) Hospital Relocation and Closure Cases

Perhaps the most well-known and therefore disappointing series of recently unsuccessful Title VI claims involve challenges to hospital closures and relocations. Because these cases have been extensively

---

[90] *C.f.* Burks v. City of Philadelphia, 950 F.Supp. 678, 683 (E.D. Pa. 1997) (holding employees claim against AIDS program director unsuccessful, alleging disparate impact from his failure to serve program purposes).
[91] 42 U.S.C. §2000d-3 (2001).
[92] Fuller v. Rayburn, 161 F.3d 516, 518 (8th Cir. 1998).

analyzed elsewhere,[93] they are mentioned here to make only a few observations. These cases have been motivated by a traditional view of what Civil Rights litigation can accomplish: where there is discrimination, the Civil Rights Law has, in the past, shone a light that provides a stark contrast between the equality standards that underlie our Civil Rights laws, and the discriminatory conduct that is caused by inequality. This has been true in the health care context as well. Traditionally, when the challenged conduct (e.g. segregating patients or excluding physicians), is compared to the legal standard requiring uniform treatment and equitable use of funds, the need for correction is easy to see and the requisite remedy is straightforward. Even where the commitment to accomplish the remedy has not been strong, the contrast between the ideal and the reality always has been. The traditional approach to hospital relocation has not worked in this fashion.

In *NAACP v. Medical Center, Inc.*,[94] the plaintiffs contended that the relocation of the Wilmington Medical Center, Inc. from its urban location would result in 75% of the available beds in inner city being removed to the suburbs. The plaintiff organizations representing African American, Puerto Rican and handicapped patients believed that the planned move plainly violated the traditional standards of fairness and equality leaving the urban population without access to care. However, the court in *Medical Center, Inc.* Court saw viewed the nine mile journey to the suburbs as one that did not "impose a significant hardship."[95] The contrast between the challenged conduct and the standard was not clear. First, the Delaware District Court was sensitive to the business related explanations the defendant gave for the move. In fact, this Court intimated that perhaps the challenged conduct was fairer to plaintiff minority residents because the patients would receive better care at the new location.[96]

---

[93] *See* Daniel K. Hampton, *Title VI Challenges By Private Parties to the Location of Health Care Facilities: Toward a Just and Effective Action*, 37 B.C. L. REV. 517, 518 (1996).

[94] Nat'l Ass'n for Advancement of Colored People v. Med. Ctr., Inc., 657 F.2d 1322 (3d Cir. 1981).

[95] *Id.* at 1332. *But see* Nat'l Ass'n for Advancement of Colored People v. Wilmington Med. Ctr., Inc., 689 F.2d 1161, 1169-70 (3d Cir. 1982)(holding plaintiffs met "prevailing party" standard for award of attorneys fees because Department of Health, Education and Welfare investigation revealed discriminatory effects of relocation plan which was voluntarily modified).

[96] Nat'l Ass'n for Advancement of Colored People v. Med. Ctr., Inc., 657 F.2d 1322, 1340 (3d Cir. 1981).

Similarly, in *Bryan v. Koch*, even where the Second Circuit acknowledged the inequitable impact of moving a hospital from its 98% minority patient base, the contrast between the legal standard and the conduct was blurred.[97] In *Bryan*, the fact of unfairness and inequality was no longer itself persuasive to compel change. Rather additional layers of requirements (e.g. the defendant's explanation had to be pretext) made the previous applications impossible. Nevertheless, there are still lessons to learn from these cases.[98]

First, these cases correctly sought to address macro-level, not micro-level forms of discrimination. These cases challenged statistically observed and demonstrable trends that had impact on entire population of minority citizens. Second, these cases are prosecuted through a collaboration of groups of individual patients, professional providers and advocacy organizations. Third, these cases identified violations of underlying statutes – in *Homer G. Phillips Hospital v. St. Louis*, for example, plaintiffs alleged violation of the Public Health Services Act and Title VI – basing claims of discrimination on notions of fairness and equality and the rule of law. These cases undoubtedly miss the mark. These attempts to use Title VI fail because they are hampered by the procedural and administrative structure of Title VI's burden shifting regime. Therefore, new ways to bring Civil Rights claims that are viable within new procedural framework are necessary. The proposal that follows does not relieve Civil Rights plaintiffs of satisfying the elements of a viable Title VI claim. Therefore, the next section briefly reviews those requirements before proceeding to the newly proposed litigation approach.

E. The Limits of Title VI Litigation

The goal of Title VI is to "safeguard against the use of federal funds in a way that encourages or permits discrimination." Even today, federally funded hospitals, nursing homes, health plans, and even physicians provide inferior healthcare to Americans who are members of ethnic minorities even though Title VI was passed to squarely address the problem of racial segregation and discrimination in health care. How is this happening? The answer is three-fold: First, part of the problem lies with the way the law has evolved to heighten the proof requirements plaintiffs must meet to make out successful Title VI claims. Secondly, the answer lies with the increasingly complex

[97] Bryan v. Koch, 627 F.2d 612, 617 (2d Cir. 1980).
[98] *Id*. at 616.

sources of racial disparity in health care. Rather than simple segregationist inequality, the sources of inequality have become more subtle and complex. Finally, the answer lies partly in the decreased funding and commitment demonstrated by the Office of Civil Rights (OCR), the administrative agency charged with Title VI enforcement. All three of these factors have been discussed extensively in existing literature. Therefore, the following discussion addresses the current law, procedure and climate for Title VI enforcement only by way of review to establish the building blocks for the new strategic arguments that follow.

1. The "Shifting Sands" Beneath Title VI Jurisprudence

Persistent discrimination is occurring in American health care, notwithstanding the fact that since 1964, Section 601 of Title VI of the Civil Rights Act has prohibited racial discrimination by federally funded programs.[99] The Supreme Court has interpreted this section of Title VI to prohibit intentional disparate treatment on the basis of race or national origin.[100] Moreover, Section 602 of that Title authorizes federal agencies to "effectuate the provisions of [§601] . . . by issuing rules, regulations, or orders of general applicability."[101] Therefore, the Supreme Court has also recognized that Title VI permitted federal agencies to promulgate regulations prohibiting discrimination due to the unintentional, disparate impact of facially neutral practices and policies.[102] In *Guardians Association v. Civil Service Commission*, the Supreme Court read Title VI to prohibit both disparate treatment and impact violations, and to clearly imply a private cause of action under

---

[99] 42 U.S.C. § 2000d (2001).

[100] *See* Guardians Ass'n. v. Civil Serv. Comm'n, 463 U.S. 582, 593 (1983) (containing a suit by minority police dept applicants challenging disparate impact of examination). Although no opinion commanded a majority, all agreed that Section 601 prohibits intentional discrimination. Majority also held proof of discriminatory effect sufficient to make Title VI claim.

[101] 42 U.S.C. § 2000d-1 (2001).

[102] *See* Alexander v. Choate, 469 U.S. 287, 292-93 (1985) (confirming *Guardians* case provided "a two-pronged holding on the nature of the discrimination proscribed by Title VI . . . . First, the Court held that Title VI itself directly reached only instances of intentional discrimination. Second, the Court held that actions having an unjustifiable disparate impact on minorities could be redressed through agency regulations designed to implement the purposes of Title VI. In essence, then, we held that Title VI had delegated to the agencies in the first instance the complex determination of what sorts of disparate impacts upon minorities constituted sufficiently significant social problems, and were readily enough remediable, to warrant altering the practices of the federal grantees that had produced those impacts.").

Title VI, though remedies available to private plaintiffs were limited to declaratory and limited injunctive relief.[103] However, in *Alexander v. Sandoval*[104] the United States Supreme Court held that while Title VI permits private individuals to sue to enforce Title VI's prohibition against intentional discrimination, and despite the validity of regulations promulgated under Section 602 of Title VI to prohibit activities that have a disparate impact on the basis of race, Title VI permits no private right of action to enforce disparate impact regulations promulgated under Section 602 of the Act.[105] In *Sandoval,* the Court considered an injunction issued to prohibit Alabama's policy of issuing driver's exams in English-only. The class action was brought by non-English speaking citizens and alleged the English-only policy of the Alabama DOJ violated Title VI by its disparate impact on non-English speakers. The Supreme Court reversed the injunction holding the plaintiffs could not bring a private action enforce disparate impact regulations under Title VI[106] because those regulations do not involve the intentional discrimination expressly forbidden under §601 of Title VI.

Several legal scholars have noted that Title VI cases, whether they alleged disparate treatment or disparate adverse impact, were rarely successful.[107] To succeed in a disparate treatment claim under this statute, a plaintiff must prove first that the defendant intentionally discriminated. This burden of proof is difficult to adduce. It comes in the form of unwitting admissions or racially biased statements. Such a "smoking gun" is rarely uncovered in professional settings today. Given the enormous difficulty of proving intent, plaintiffs have long favored the disparate impact cause of action available under Title VI.
Notwithstanding the lesser challenge of discharging the evidentiary burden to make out a disparate impact claim under Title VI, the most significant obstacle to plaintiffs wishing to bring these disparate impact claims has little to do with proof. Now that *Alexander v. Sandoval* has

---

[103] *Guardians*, 463 U.S. at 584.
[104] Alexander v. Sandoval, 532 U.S. 275 (2001).
[105] *Id*. at 287.
[106] *Id. See generally* Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 YALE J. HEALTH POL'Y., L. & ETHICS 215 (2003) (discussing *Alexander v. Sandoval* and its implications).
[107] *See* Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval,* 3 YALE J. OF HEALTH POL'Y., L. & ETHICS 215, 226 (2003).

eliminated the private avenues for enforcement of Title VI disparate impact claims, only two alternatives remain. A private plaintiff may still obtain injunctive and declaratory relief under Title VI for intentional discriminatory treatment, or vigilant and committed administrative agencies can enforce the disparate impact regulations promulgated under Title VI. Unfortunately, there is no evidence of any such commitment in the current administration. In fact, much has been written to confirm that where healthcare is concerned, Title VI enforcement to eliminate racial disparity and injustice is no longer a priority.[108] One commentator has opined that the "timid and ineffectual enforcement efforts of the government through the Office of Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) have fostered, rather than combated, the discrimination that continues to infect the nation's health care system."[109] This retreat by the federal government comes at the most inopportune time. David Barton Smith has described the medical industry's "adaptations" that make sources of discrimination more complex and difficult to identify than ever.[110]

The Institute of Medicine's Report provides the latest in a compelling body of data and statistical evidence that confirms what some call health care "disparities," but what must plainly be seen as inequality and injustice of the most inhumane sort. The need for a revival of the legal remedy most precisely tailored and historically suited to address racial injustice in health care is urgent. The next section proposes an approach to Title VI litigation intended to effect such a revival.

---

[108] *See* David K. Hampton, *Title VI Challenges by Private Parties to the Location of Health Care Facilities: Toward a Just and Effective Action*, 37 B.C. L. REV. 517, 524-25 (1996) (". . . OCR has almost completely abdicated its Title VI health care monitoring and enforcement responsibilities"); Sidney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C. L. REV. 1647, 1669 (1993) ("The most fundamental shortcoming of OCR's Title VI enforcement effort is that it has produced no data for evaluating Title VI compliance").

[109] Vernellia R. Randall, *Racial Discrimination in Health Care in the United States as a Violation of the International Convention on the Elimination of all Forms of Racial Discrimination*, 14 U. FLA. J.L. & PUB. POL'Y 45, 72 (2002) (stating that OCR has not sufficiently prepared its investigative staff to identify and confront instances of discrimination).

[110] *See generally* Fox Update, http://newsweaver.ie/foxbusinessupdate/e_article000308770.cfm?x=b11,0,w.

II. USING THE CIVIL FALSE CLAIMS ACT TO ENFORCE TITLE VI PROHIBITIONS AGAINST DISCRIMINATION IN HEALTH CARE

This article proposes that private individuals resume filing disparate impact Title VI claims indirectly, despite the Supreme Court's holding in *Alexander v. Sandoval*, by using a vehicle under the Civil False Claims Act (FCA)[111] called a "false certification claim." If successful, this approach would not only allow private parties to resume prosecuting disparate impact cases under Title VI, but it would also permit suit against any type of provider, ranging from large networks, to sole practitioners, to government entities. These providers would be held accountable for the disparities caused by their systems-or care-level policies, based on statistics, studies and data already available today. The mechanics of bringing a false certification claim is best understood in two steps. First, I explain how an ordinary FCA claim works. Second, I explain the "false certification" variant of an FCA claim which is the vehicle that would allow Title VI, disparate impact claims to be privately prosecuted as fraud.

---

[111] *See* 31 U.S.C. §3729 (2001) *et seq.* The FCA provides in pertinent part, as follows:

> (a) Liability for certain acts. Any person who:
> (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
> (2) knowingly makes, uses, or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the Government;
> (3) conspire to defraud the Government by getting a false or fraudulent claim allowed or paid
> . . .
> (7) knowingly makes, uses or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government
> is liable to the United States Government for a civil penalty of not less than [$5,500] and not more than [$11,000], plus 3 times the amount of damages which the Government sustains because of the act of that person . . . .

See also Omnibus Consolidated Recessions and Appropriations Act of 1996, Pub.L. No. 104-134, §31001(s)(1), 110 Stat. 1321 (1996); *see also* Civil Monetary Penalties Inflation Adjustment, 64 Fed. Reg. 47,104 (August 30, 1999).

1. An Overview of the Civil False Claims Act

The FCA statute prohibits a government contractor from knowingly submitting or causing to be submitted, a false or fraudulent claim for payment to the United States Government.[112] In the health care context, any provider who is reimbursed by the Federal Government, is a government contractor whose conduct is controlled by the FCA. The claims for payment in health care are simply the provider's requests for reimbursement for medical goods or services, submitted to the Government. These claims for reimbursement are the subject of the FCA. Under this statute, three elements must be proved for a plaintiff to prevail on an FCA claim. First, the plaintiff must prove that a claim or statement for payment was made. Second, the claim for payment must have been false or fraudulent. That is to say, the plaintiff must prove falsity. Third, the plaintiff must prove the false claim or statement was made knowingly. Under this statute, "knowingly" may mean the defendant had actual knowledge that the claim was false, but it may also mean the defendant acted in "reckless disregard" or with "deliberate indifference" to the truth or falsity of the claim submitted. If proved, violation of the FCA will cost defendant providers a civil penalty ranging from between $5,500 and $11,000 for each individual claim for payment filed, plus three times the damages the government has incurred by paying the false or fraudulent claim.

The FCA's *qui tam* provision makes it particularly attractive as a vehicle to prosecute Title VI offenses.[113] This section of the FCA creates a private cause of action, allowing individuals to bring suit on behalf of the United States Government, against those suspected of fraudulent billing against the public fisc.[114] The FCA was originally enacted in 1863 and was called "Lincoln's Law" because its objective

---

[112] 31 U.S.C. §3729 (2001).

[113] BLACK'S LAW DICTIONARY 1282 (8th ed. 2004) ("Qui Tam" is a truncation of the Latin phrase, "qui tam pro domino rege quam se ipso in hac parte sequtur." This phrase describes actions brought by a private party, on behalf of the government. The approximate translation of the entire Latin phrase is: "he who brings action for the king as well as for himself.").

[114] 31 U.S.C. §3730 (2001) (setting out the Private Cause of Action under the FCA. It reads:

> (b) Actions by Private Persons. (1) A person may bring a civil action for a violation of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting. . . .).

was to stop fraudulent sales of inferior supplies to the Government during the Civil War. The statute was intended to encourage private parties who knew of fraud, to help prosecute that fraud as private attorneys general, or more colloquially, as a "whistleblower."[115] The private plaintiff who brings an action under the *qui tam* provision of the FCA is called the "relator" because that person relates facts that constitute fraud on so that the Government can recover its own money. In exchange for the inside information about fraud, and the prosecutorial assistance the Government receives, the FCA allows the *qui tam* relator to share in the proceeds of the litigation.

Until 1986, few plaintiffs took advantage of the *qui tam* provision. However, in 1986, Congress substantially increased the percentage share of damages and judgments that a private plaintiff receives in successful *qui tam* enforcement. Now, depending on whether the Government joins the relator's lawsuit to take over the prosecution, or allows the relator to prosecute the suit independently, the plaintiff can receive between 15 and 30 percent of the trebled damages or settlement amount from a case.[116] As a result, *qui tam* relators who successfully sue health care providers are regularly earning tens of millions of dollars for their assistance to the Government.[117]

---

[115] *Id.*

[116] 31 U.S.C. §3730 (2001) (stating that the *qui tam* relator's share under reads as follows:

> (d) Award to Qui Tam Plaintiff. (1) If the Government proceeds with an action brought by a person under subsection (b), such person shall . . . receive at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim. . .
>
> (2) If the Government does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an amount which the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of such proceeds. Such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.).

[117] *See* John F. Murphy, *What Are the Rewards? Examples of Recoveries by Whistleblowers*, http://www.whistleblowerlawyer.com/reward.htm (showing the DOJ Annual Report for FY 2004 with sample recoveries such as $22 to the relator in a case against United Technologies, Inc. involving helicopter contract; $18.5 million paid to the relator who filed against Lucas Industries, Inc. to allege falsification of gear box records on Navy fighter jets and Army rocket launchers).

Health care providers make especially attractive defendants under the penalty and treble damages structure of the FCA. This is because penalties apply to each false claim filed by a defendant. In the case of a health care provider, each time the Government is billed for a procedure, service or facility use, a potentially false claim has been filed. Large provider networks may file hundreds of thousands of claims annually and these, if false, could result in enormous recoveries. Take this simple example as an illustration: Assume a small, 300-bed hospital incorrectly claimed reimbursement for needle syringes at some premium above their actual cost. If the hospital overcharged in this way for a period of five years, then the hospital could be fined a civil penalty for each and every time the hospital submitted a claim to be reimbursed for the inflated cost of a syringe during the relevant period. Moreover, if an FCA violation is proved, the defendant found liable under the FCA must pay *treble* the damages the Government suffered as a result of the false claims. This is measured as the difference between what the Government did pay to reimburse the defendant provider based on the claim submitted, and what the Government *would have paid* had the claim not been false. If syringes are ordered in lots of a thousand, once monthly at a cost of $100 but were billed at $125, then for each order over the five year period, the defendant could be held liable for $11,000 for each monthly shipment made during the relevant five-year period, *plus* three time $25 for each box of 1000 syringes the defendant ordered. The 300-bed hospital in our example most likely uses a box of 1000 syringes every day. One can quickly see that the potential liability the defendant faces grows exponentially with the number of syringes ordered and the length of the time period the incorrect billing occurred. As the defendant's exposure to liability under the FCA grows, so does the size of the private *qui tam* plaintiff's percentage share in proceeds from the suit. As a result, plaintiffs have been active and creative in developing theories of recovery under the FCA. The false certification claim is an example.

2. False Certification Claims Under The FCA

False certification claims are a specialized type of FCA claims that allow plaintiffs to bring an otherwise unavailable underlying charge against the defendant, because the underlying charge is literally wrapped inside a false claims allegation under the FCA. Here is how the false certification claim works. The plaintiff first identifies an underlying statute, independent of the FCA itself, that a defendant allegedly has violated. For our purposes, that underlying statute will be

Title VI of the Civil Rights Act. Next, the plaintiff identifies the claims for reimbursement that the defendant presented to the Government during the period when the defendant was not complying with the letter and spirit of the underlying law – in our case, Title VI and accompanying regulations. The crux of the false certification claim is the plaintiff's assertion that the defendant certified, either expressly or impliedly,[118] that it was compliant with all federal law in order to claim reimbursement for goods and services from the United States Government and the Government viewed such a representation as a condition of payment or reimbursement. If it turns out that the defendant did not comply with the underlying law, then the defendant's certification and claim for payment submitted to the Government are both false and actionable under the FCA.

The Sixth Circuit Court of Appeals recently affirmed the appropriateness of applying the false certification action to health care providers. In *United States ex rel. Augustine v. Century Health Services, Inc.*[119] the Court held a home healthcare agency company liable for treble damages and penalties under the FCA for misuse of Medicare reimbursements withdrawn from the company's Employee Stock Ownership Plan (ESOP). The *Augustine* case was filed by a *qui tam* plaintiff to allege that the defendants had breached their fiduciary duty to the ESOP. Citing the Supreme Court's observation that the FCA is "intended to reach all types of fraud, without qualification, that might result in financial loss to the Government,"[120] the Sixth Circuit endorsed the implied certification theory of recovery under the FCA. First, the Court found that the defendant's cost reports contained a certification that "to the best of its knowledge and belief, [the cost report] is a true, correct, and complete report prepared from the books

---

[118] Ideally, the plaintiff can identify a form or document the defendant submitted as part of the claim for payment which contains an express representation or certification that the defendant is in substantial compliance with all other controlling law. In our hypothetical, that certification would apply to compliance with Title VI as well. In other contexts, plaintiffs have found such a certification when providers submit HCFA form UB-92'2 or HCFA 1500's to be reimbursed. If this is the case, then an express certification that the defendant is compliant with federal law will serve as the basis to satisfy the falsity element of an FCA claim. On the other hand, if no express certification of compliance is available, the plaintiff may argue the defendant impliedly certified compliance with Title VI and that the Government would not have reimbursed for medical goods and services if it knew the defendant was violating the Federal Civil Right Law at the time it requested reimbursement.

[119] United States v. Century Health Services, 289 F.3d 409, 411 (6th Cir. 2002).

[120] *Century Health*, 289 F.3d at 413, *quoted in* United States v. Neifert-White Co., 390 U.S. 228, 232 (1968).

and records of the provider in accordance with applicable instructions…"[121] Next, the Court reasoned that by making this certification, the Defendants represented they would comply with Medicare regulations."[122] When the Court found the defendants in fact had violated Medicare regulations that control ESOP expenses, the *Augustine* Court was able to conclude that the defendant's costs reports were false claims for payment, filed in violation of the Civil False Claims Act. The Court said,

> A number of courts have held that a false implied certification may constitute a false or fraudulent claim even if the claim was not expressly false when it was filed. Instead, liability can attach if the claimant violates its continuing duty to comply with the regulations on which payment is conditioned. We adopt this theory of liability, and conclude that the district court did not err in finding it applicable in this case.[123]

In *Mikes v. Straus,*[124] the Second Circuit similarly adopted the false certification theory of recovery under the FCA. In that case, a pulmonologist filed the *qui tam* action against his physician partners,[125] alleging they violated the FCA by failing to properly calibrate instruments used to provide medical care for which the federal government was billed. The gravamen of the relator's claim in that case was that the defendant's claim for reimbursement under Medicare was false because it sought payment for services not rendered in accordance with the relevant standard of care. In this case, the *qui tam* relator relied on the defendants HCFA-1500 forms to find the express certification that said "I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me…" As this certification is a precondition of the government's payment, the *Mikes* Court concluded any underlying failure to comply with the certification rendered it false and therefore actionable under the FCA.[126] The *Mikes* court went further to endorse the theory of implied as well as express certification,

---

[121] *Century Health Services*, 289 F.3d at 414.
[122] *Id*. at 415.
[123] *Id*.
[124] Mikes v. Straus, 274 F.3d 687 (2d Cir. 2001).
[125] *Id*. at 692.
[126] *Id.* at 698.

whenever the underlying statute or regulation upon which the FCA claim is based expressly states that a provider must comply in order to be paid.[127]

The false certification theory of recovery has been particularly successful in cases brought to enforce the antifraud provisions of the Medicare Anti-Kickback statute, and Stark I, II and III legislation. In *Pogue v. American Healthcorp, Inc.*,[128] for example, a private qui tam relator filed a FCA suit against his former employer to prosecute defendant physicians' referrals of Medicare and Medicaid patients to defendant's centers for treatment. The *qui tam* relator in *Pogue* could not have prosecuted this alleged violation of the anti-kickback and self-referral laws directly because neither of these statutes creates a private cause of action. This is directly analogous to the Supreme Court's decision to quash private causes of actions to prosecute disparate impact violations of Title VI. In *Pogue*, the court reasoned that violations of the anti-fraud statutes were actionable under the FCA under the false certification theory. Reasoning that the government would not have paid Medicare reimbursements if it had known the defendants conduct violated anti-fraud laws, the court concluded the defendant's claims for Medicare reimbursement filed while in continuing violation anti-fraud law were false.[129] This theory is directly applicable to Title VI claims. Although the Courts no longer recognize a private cause of action under Title VI, to the extent that health care providers file claims for reimbursement while operating in ongoing violation of its non-discrimination provisions, those claims for payment are false and actionable under the FCA. *Pogue* is somewhat limited in its reach; however, because of the Fifth Circuit's decision to imply falsity from an inference that the defendants in that case deliberately hid their anti-kickback violations from the government with the intention of obtaining Medicare reimbursements the government otherwise would not have paid if the defendants' conduct had been revealed.[130]

More instructive, however, is a Fifth Circuit *qui tam* case styled *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*[131]

---

[127] *Id.* at 697.
[128] United States ex rel. Pogue v. American Healthcorp, Inc., 914 F.Supp. 1507 (M.D. Tenn. 1996).
[129] *Id.* at 1513.
[130] *Id.*
[131] United States ex rel. Thompson v. Columbia/HCAHealthcare Corp., 125 F.3d 899 (5th Cir. 1997), *remanded to* 20 F.Supp.2d 1017 (S.D. Tex. 1998).

Two types of FCA violations recognized in *Thompson* are worth examining as potential models for Title VI-based FCA claims. The first does not involve the false-certification theory, but rests on a *per se* finding of liability. The *Thompson* Court found that claims submitted for reimbursement by providers who were in violation of the Stark II Law,[132] at the time their claims were submitted, were *per se* actionable as false and fraudulent claims under the FCA.[133] The underlying Stark Law prohibits physicians from referring to entities that provided designated health services, and with which either the physician or a member of the physician's immediate family has a financial relationship. This statute not only prohibits physician self-referrals, but it also prohibits entities from billing Medicare for services that are the result of physician self-referrals.[134] Therefore, the *Thompson* Court reasoned that an entity that knowingly submitted a claim for reimbursement generated by a physician self-referral, prohibited by the Stark statute, submitted a necessarily false claim. By analogy, it could be argued that any publicly funded provider who submits a claim for reimbursement while operating in a way that "exclude[s] from participation in, … denie[s] the benefits of, or . . . subject[s] [a person to] discrimination" on the basis of their race, color or national origin has submitted a *per se* false or fraudulent claim in violation of the FCA.

A second strain of reasoning from *Thompson* may also prove applicable in the Civil Rights context. The Fifth Circuit approved a version of the false-certification claim in *Thompson* that is instructive. There, the Court read the defendant's annual cost reports as express certifications that it had complied with all Medicaid and Medicare regulations.[135] Notwithstanding this representation, the Court also found the defendant had violated both the Stark Law and the anti-

---

[132] *Id*. at 902; 42 U.S.C. §1395nn (1994 & Supp. IV 1998) (amended 1992) [hereinafter "the Stark Law" will refer to Stark I and Stark II which were enacted in 1989 an 1993 respectively but which are together prohibition of the practice of physician self-referral].

[133] *Thompson*, 20 F.Supp.2d at 1047.

[134] The Stark Law, 42 U.S.C. §1395nn(a)(1) (2001). The Stark Law provides:

> (A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this subchapter, and
> (B) the entity may not present or cause to be presented a claim under this subchapter or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A)). *Id.*

[135] *Thompson,* 125 F.3d at 902.

kickback statute.[136] The anti-kickback statute's criminal provisions prohibit knowingly paying or receiving any remuneration in exchange for patient referrals, for goods and services paid for by federal health care programs.[137] Unlike the *per se* liability that attached under the first theory of liability, here the *Thompson* court found the defendant's claims were false because they were inconsistent with the representation that the defendant had complied with the law. Thus, these claims were falsely certified as compliant and this discrepancy made the claims actionable under the FCA. The *Thompson* Court emphasized the importance of the fact that the government had relied upon the defendant's ultimately false representation in making its reimbursement payments.[138] Applying the *Thompson* Court's false certification analysis from this second category of FCA claims to prosecute Title VI violations will require a similar showing of the Government's reliance on a representation that the defendant certified compliance with federal law. Forms required for Medicare and Medicaid participation such as the HHS-441 require providers to affirm their willingness to comply with Title VI. This is the type of documentation may evince the Government's general unwillingness to pay for discriminatory services. Although the FCA does not explicitly require the plaintiff to satisfy an injury element, the Government and *qui tam* relators will be attracted to prosecuting cases against defendants who have cost the government money. The treble damages provision of the FCA turns on a showing that the government was damaged by the alleged underlying violation. Therefore, the success of applying *Thompson's* false certification theory to Title VI claims will depend upon convincing a fact-finder that the Government relied upon and would not otherwise have paid to reimburse providers for goods and services delivered by providers who do not comply with Title VI.

a) Special Logistic and Substantive Considerations

Applying the *Thompson* false certification and *per se* liability models to prosecute Title VI violations *via* the FCA will require civil rights advocates to address some special concerns. First, the false certification theory has succeeded where the courts concluded that the

---

[136] 42 U.S.C. §1320a-7b (2001) (containing a criminal provision of the Medicare and Medicaid Anti-Fraud Act referred to herein as the "anti-kickback statute").

[137] 42 U.S.C. §1320a-7b(a)(1)-(2) (2001) (prohibiting false statements or representations of material fact in application for federal health benefits, something not at issue in *Thompson*).

[138] *Thompson*, 20 F.Supp.2d at 1047.

Government's decision to pay the claims in question was conditioned on the defendant's representation that it complied with the underlying statute.[139] The FCA claim to enforce Title VI must represent either that the statute conditions Medicare reimbursement on compliance, or that the Government never would reimburse a healthcare provider who failed to comply with Title VI.[140] Second, Title VI employs a burden-shifting procedure that must be incorporated into the FCA claim. In disparate impact cases, after a *qui tam* relator is able to show *prima facie* violation of Title VI's anti-discrimination provision, the relator will also have to show that it could discharge its subsequent burden to show there is no feasible alternative policy that would have less of an adverse impact on racial and ethnic minorities.

There are several advantages to prosecuting Title VI claims by the FCA. First, the FCA will allow Title VI claims for disparate impact to be brought by private parties. Second, although the plaintiff will have to prove the elements of the underlying Title VI claim are satisfied, this can be done without the administrative requirements to file a complaint, seek voluntary compliance, and exhaust all the other administrative remedies required to enforce Title VI through the Office of Civil Rights. Third, the FCA's scienter requirement relaxes the intent requirement that a direct Title VI claim might require. Fourth, the FCA claimant need not prove materiality or direct injury to state a colorable claim. However, the statute's objective is to redress fraudulent spending of the public fisc. Therefore, any cognizable FCA claim must serve this goal.[141]

In summary, the Title VI violations most amenable to FCA prosecution will be those that implicate specific policies and practices that cause a quantifiable disparate impact on minority patients and populations, while also resulting in a demonstrable impact on the Federal treasury because the government would not have reimbursed for the medical goods or services provided had it known of the Title VI violation alleged. A final observation is appropriate. Because there are many cases in which the FCA would be a poor substitute for existing

---

[139] *See* Mikes v. Straus, 274 F.3d 687, 700 (2d Cir. 2001).

[140] CENTERS FOR MEDICARE & MEDICAID SERVICES, HCFA 1450, *available at* http://www.cms.hhs.gov/providers/edi/h1450.pdf (containing a certification that the provider claiming reimbursement has complied with the Civil Rights Act of 1964 and this language should prove helpful in fashioning a colorable FCA claim).

[141] *See* United States ex rel. Thompson v. Columbia/HCA Healthcare Corp., 20 F.Supp.2d 1017, 1048 ("in light of the legislative history and the purpose of the FCA that submission of such claims for services that were statutorily ineligible for payment under the Medicare Act constitutes a false claim within the ambit of the FCA.").

laws that directly control the conduct of health care providers. Here, the argument that Title VI litigation should proceed under the FCA must be distinguished. First, the FCA is appropriate where the Federal enforcement authority has either lost or abdicated its ability to administratively address the violations of the underlying law. Second, the FCA is an apt substitute for direct enforcement where the precise objectives of the underlying law are unambiguous and will be precisely served by FCA litigants. Finally, where the Federal Government expressly requires certification that government contractors comply with a specific statute before receiving reimbursement, the FCA approach is particularly well suited for prosecuting violators of that certification.

3. Limits of the False Certification Cause of Action

Notwithstanding the advantages of using the FCA as a mechanism for revitalizing Title VI to address racial injustice in health care, the potential for misapplication of the FCA false certification claim warrants an attempt to distinguish those claims that are suitable for FCA enforcement, from those that are not. The *Thompson* defendants cautioned that the FCA could not to be the "stalking horse" for every statutory and regulatory violation, turning the anti-fraud statute into a "mega-remedy."[142] This must be correct. For example, in *United States ex rel. Joslin v. Community Home Health of Maryland, Inc.*[143] a District Court refused to use the false certification claim proposed by a *qui tam* plaintiff to enforce state licensing laws allegedly violated by a home health agency. Therefore, this section provides a short list of features to distinguish Title VI disparate impact cases as claims that may be properly enforced through the FCA.

First, Title VI is a federal statute so that FCA enforcement would not preempt state law in any way. Second, the statutory and regulatory objectives and provisions of Title VI and accompanying regulations are unambiguous. Title VI violations do not arise from good faith efforts to interpret or apply a complex or changing body of detailed regulatory provisions. This distinguishes Title VI from attempts to use the false certification claim to prosecute error rather than fraud. Third, FCA enforcement will directly serve the Congress' intent in prohibiting the use of federal funds to provide discriminatory health care and treatment. Fourth, the FCA's *qui tam* provision will

---

[142] *Thompson*, 20 F.Supp.2d at 1025.

[143] United States ex rel. Joslin v. Cmty. Home Health of Maryland, Inc., 984 F.Supp. 374, 379 (D. Md. 1997).

allow the government to enlist the help of insiders to identify discriminatory polices that are subtle, complex and difficult to identify without the assistance of private participants in litigation. Just as the government has relied on *qui tam* relators to help prosecute subtle and complicated schemes that violate the plain prohibitions of the Anti-kickback and Stark laws, the FCA will prove useful to root out subtle forms of discriminatory conduct that plainly violates Title VI. This paper does not propose to replace existing legal duties or standards of care with new ones under the FCA. It does not propose to replace a properly functioning administrative regime, with private litigation intended to usurp the government's existing exercise of enforcement authority. To the contrary, the FCA is proposed here as a tool to enforce Title VI where those charged with its enforcement have fallen short. In fact, Civil Rights advocates may wish to explore one further, novel application of the FCA to enforce Title VI: direct actions against the Office of Civil Rights itself.

4. Suits against The Government – Suing OCR

The due process protections of the Constitution protect the adjudicatory process under Title VI. A complainant who files with OCR has the right to have that agency consider the merits of its charge and failing to do so creates a property right protected by the Constitution.[144] To the extent that the evidence is clear that these rights are not being vindicated, an appropriate solution may include bringing suit against the Government to compel its enforcement obligations under Title VI as vindication of beneficiaries' property rights.[145]

Others have sued OCR and lost. However, this is not to say that bringing suit against OCR is necessarily a losing cause. OCR is, as many commentators have noted, woefully under-funded and under motivated to use Title VI as a tool to eradicate racial inequality. Most recently, an individual plaintiff, joined with health care advocacy groups to bring suit against the Department of Health and Human Services (DHHS) and the acting director of the Office of Civil Rights (OCR) in *Madison-Hughes v. Shalala*. The plaintiffs in that case alleged the government violated Title VI by failing to collect data and publish guidelines to carry out its effectively enforce the non-

[144] *See* Logan v. Zimmerman Brush Co., 455 U.S. 422 (1982).

[145] This effort might be supported by a grass roots effort to identify and file numerous claims of discrimination with the OCR, in order to establish a pattern and practice of discriminatory non-enforcement. This effort would be reminiscent of the grass roots campaign that led to the passage and enforcement of Title VI in the 1960's.

discrimination provisions of Title VI.[146] Their claim was that Title VI and its implementing regulations required data collection for effective enforcement of the anti-discrimination law. According to the *Madison-Hughes* plaintiffs, HHS had unlawfully filed to collect data to report the ethnic distribution of patients treated by federally funded health care providers; measures of racial integration by health providers. Both the District Court and the Sixth Circuit Court of Appeals disagreed. Finding no mandatory requirement that HHS collect statistical data in either Title VI or its accompanying regulations,[147] the Court dismissed the claims in this case for lack of subject matter jurisdiction. The errors plaintiffs made in *Madison-Hughes v. Shalala*, provide useful lessons for us today:

First: Identify the mandates of the statutes and regulations that govern OCR. Addressing the jurisdiction issue that defeated plaintiffs in *Madison-Hughes*, a well-pled complaint must firmly ground the violations alleged against OCR in the plain language of the statute's mandates. A federal court may exercise jurisdiction to review agency's discretion if "the statute provides a meaningful standard against which to judge the agency's exercise of discretion."

Second, it may be necessary to generate a record of non-enforcement over which Civil Rights advocates have control in order to prove the OCR's inactivity. Rather than relying upon the OCR to report the number of cases that have been filed and their respective disposition, a grass roots effort to flood the OCR with a carefully coordinated and recorded series of complaints that are all followed closely may build a record of the type of failure to fulfill a statutory obligation that may ultimately be actionable.

Finally, the *Madison-Hughes* Complaint did not include a count based upon 45 C.F.R. §80.7(b) that allows complaints to ensure Title VI enforcement. This is a basis of recovery to consider in future enforcement efforts.

III. CONCLUSION AND RECOMMENDATIONS

Rumors of the demise of effective Civil Rights litigation in health care, are woefully premature. A most troubling series of judicial defeats have led to justifiable concern among advocates and legal scholars.

---

[146] *See* Madison-Hughes v. Shalala, 80 F.3d 1121, 1123 (6th Cir. 1996).

[147] *See id.* at 1126-27 (dismissing 45 C.F.R. §80.6(b) as a "mechanism of enforcing the Act . . . *at times*" making it discretionary and not mandatory). Similarly, the Court held 28 C.F.R. §42.404(a) does not mandate any routine data collection. *Id.*

However, an ever increasing and damning body of evidence of racial injustice and inequality in American health compel continued diligence and creativity in the effort to address racial injustice in health care. This paper proposes the use of a statute that has proved effective to re-create private causes of action, where none previously existed. The FCA's attractiveness includes its lack of focus on specific injury, the usefulness of employing the assistance of inside *qui tam* plaintiffs motivated by the prospect of their own financial recovery; the flexibility of proof requirements that avoid administrative complexities in favor of straight-forward judicial determinations of the underlying violations; and the statute's treble damages provision.

If the FCA is used to bring actions for which there is substantial statistical data of disparate impact, then the lessons learned from early and recent Title VI cases that have met with success can be incorporated in a statute that is easily applied to the health care context. It has been said that desperate times call for desperate measures. Where racial and ethnic injustice in healthcare is concerned, these are such times indeed.

Table 1
Plaintiffs' Success in Title VI Health Care Cases
1967 – 2004

Year	Case	Holding	Title VI Evidence	Success?
1967	Cypress v. Newport News Gen Hosp (4th Cir.)	Black MD and his patients denied admission to hospital and staff privileges bring class action. Held: Evidence compels inference of discriminatory *treatment* by race.	70% of white MD's but no Black MD's in community on staff. Plaintiffs with outstanding record rejected. Hospital offered no reason and took race in acct.	Yes
1969	Marable v. Alabama Mental Health Bd (D.C. Ala)	Patients sue mental institutions challenging employment practices and segregation. Held: Equal Protection violation; allow 12 mo to deseg →Title VI compliance to keep federal funds	Segregated mental institutions where Black facility separate and inferior facilities, with inferior staff and MD's and expenditure per patient.	Yes
1972	Coleman v. Humphreys County Mem Hosp (N.D. Miss)	Class action v county hospital by Black residents to enjoin operating discriminatory manner. Held: Injunction Awarded	Long, steadfast resistance by hospital and county to change policies	Yes

1976	Battle v. Jefferson Davis Mem Hospital (D.C. Miss)	Black MD sued public county hospital and Bd /Trustees. Held: Rejection of Plaintiff's application not racially motivated, arbitrary or irrational	No Black MD on staff (1 dentist) but background check on Plaintiff MD showed mental health and drug abuse history; fabricated residency; unexplained resignation	No
1979	Jackson v. Conway (E.D. Mo)	Plaintiff advocacy groups and providers sought preliminary injunction to compel HEW to investigate closure and consolidation of city hospitals. Held: Plaintiffs have standing but must first exhaust admin remedies under Title VI	Sup Ct said med care "basic necessity of life" in Maricopa Hospital case but plaintiffs submitted HEW complaints only 30 days b/4 and no policy guidelines show when hospital closure can violate Title VI.	No

1979	NAACP v. Medical Center, Inc (3rd Cir.)	Plaintiff civil rights groups representing minority and handicapped sue state and HEW and federal planning council to challenge med center's relocation plan would have *disparate impact* on minorities. Held: Relocation will improve health delivery for all, without substantial discriminatory effects upon minorities but can *infer* private COA	Med cntr that provides 75% of beds in area plan to relocate tertiary care from inner city	No

1980	Bryan v. Koch, (2nd Cir.)	Plaintiff advocates and unions (3 consolidated suits) representing Black and Hispanic Harlem residents sue City and state to seek preliminary injunction, alleging closure of Sydenham Hospital violates Title VI by *disparate impact* on minority patients w/o showing no alternative available. Held: Plaintiffs have shown sufficient disparate impact to require answer by Defendants. Defendants cite increased efficiency and conducted system wide survey. Held: Defendant City showed it considered alternatives, no Title VI success for Plaintiffs likely. Disparate impact evidence not effects required.	98% of Sydenham's patients are Black or Hispanic	No

1980	U.S. v. Bexar County (D.C. Tex)	Advocacy citizens and groups sue defendant hospital to challenge move of inpatient maternity and newborn services from downtown San Antonio result in discriminatory *impact*. Held: No evidence of discriminatory impact or intent	Despite inconvenience to mothers, benefits from increased quality outweigh; Hospital has provided bus and notice, will keep outpatient facility and patients use automobiles so can travel.	No
1982	Sumpter v. Harper (4th Cir.)	Patient sued for medical malpractice alleging Title VI disparate *treatment.* Held: Title VI gives no right to redress negligent treatment by MD		No
1982	Chowdhury v. Reading Hospital (3rd Cir.)	Physician "not of Caucasian race" licensed to practice but denied courtesy staff privileges at defendant Hospital, sues claiming disparate *treatment* violates Title VI. Held: Plaintiff need not exhaust agency funding or administrative remedies before filing D.		Yes

1983	Wrenn v. Kansas (D.C. Kansas)	Black plaintiff sues state, university and university hospital alleging a failure to hire him as administrator was disparate *treatment*. Held: Plaintiff has properly pled Title VI claim of disparate *treatment* but has not shown either exhaustion of admin remedies or why not required in Title VI		No
1983	Vuciecevic v. MacNeal Memorial Hosp (D.C. Ill.)	Serbian-Yugoslavian M.D. sued defendant hospital and professional corporation alleging denial of privileges was disparate *treatment* violating Title VI. Held: Plaintiff MD not intended beneficiary under Medicare/Medicaid. No nexus between fed funds used and the alleged practice		No

1986	Doe v. St. Joseph Hospital (7th Cir.)	Korean-American MD sues for termination of staff privileges based on national origin following confrontation with another MD who filed complaint. Held: Title VI claim dismissed b/c MD not intended beneficiary of federally funded programs and plaintiff alleges no discrimination vs. patients b/c of race		No
1986	Bhatt v. Uniontown Hospital (W.D. Penn)	MD denied staff privileges sues claiming deial discriminatory. Held: Title VI applies to hospital recipient of Medicare/Medicaid but not to privileges matter where no correlation between MD privileges and receipt of fed funds		No

1987	Griggs v. Lexington Police Dept. (D. Mass)	*Pro se* plaintiff injured in auto accident while walking. Along with allegations of prejudice 3 yrs ago by Lexington Police, Plaintiff alleged racial discrimination which Ct made into Title VI claim and then dismissed for failure to allege Plaintiff = intended beneficiary. Held: No nexus b/t fed funds receipt and plaintiff's participation in program.	Hospital gave poor medical care, caused humiliation, treated differently (e.g. food trays) because of race.	No

1990	Linton by Arnold v. Comm'r of Health and Environment, Tenn. (6th Cir.)	Class action by Black Medicaid-eligible patients excluded from nursing home beds, challenged Tennessee's limited bed certification policy under Medicaid Act's "distinct part certification." Policy allowed SNF spot certified beds for Medicaid participation and Dist Ct held Title VI violation, policy caused *disparate impact* on minority access to nursing homes. Held: No need to find whether disparate impact on blacks since policy violated Medicaid Act.	23% Tenn Medicaid participating nursing homes had limited bed policy; 7% of beds uncertified that would've been	Qualified, Yes

1992	United States v. Harris Methodist Fort Worth (5th Cir.)	U.S. seeks declaratory judgment Title VI entitled it to investigate defendant's physician peer review and staff privilege records but that the 4th Amendment reasonableness requirements were inapplicable. Held: Title VI applies to physician staff privilege decisions; HHS Searches must be reasonable w/in 4th Amend but this one is not reasonable		Yes, Title VI applies but 4th Amend controls

1992	Homer G. Phillips Hosp v. St. Louis (E.D. Mo)	Black city residents and advocacy groups brought class action suit to challenge hospitals consolidation and relocation of acute outpatient from city to regional hospital b/c violated Public Health Svces Act and Title VI, denying access to Black, Hispanic, handicapped & indigent patients. Held: Plaintiffs lack standing, having shown no evidence personally injured by denial of medical care or access	Homer G. Phillips hospital removed inpatient acute care facility and transferred to regional, 3 miles away and accessible to public transportation.	No
1993	Vakharia v. Swedish Covenant Hospital (N.D. Ill.)	Plaintiff MD from Bombay, India, sued hospital alleging termination of her staff privileges violated Title VI (and other) prohibition. Held: MD not intended beneficiary of federal funds to hospital.		No

1993	Mussington . St. Luke's-Roosevelt Hospital Center (S.D. NY)	Individual Black and Latino minority plaintiffs, advocacy and church organizations brought action alleging hospital relocation discriminated against Medicaid patients on basis of race. Held: Organizational plaintiffs lacked standing. Laches and statute of limitations barred suit alleging disparate *treatment and impact*		No
1993	Baker v. Bd of Regents of Kansas (10th Cir.)	White, male applicant with highest GPA/MCAT of rejected Kansas resident claims reverse discrimination violated Title VI. Held: Barred by statute of limitations		No

1994	Atakpa v. Perimmeter OB-GYN Associates (N.D. Ga. 1994)	Patient. Nigrerian immigrant sued clinic and nurse-midwife alleging national origin discrimination w/r/t HIV testing violating Title VI and sought summary judgment.	Defendant terminated plaintiff's treatment when she refused HIV testing but did not terminate non-African patients who similarly refused.	Yes
1994	Fobbs v. Holy Cross Health Care System, Corp (9th Cir.)	Black MD sued on behalf of self and Black patients to challenge Held: States Title VI claim for personal racial discrimination (treatment) but despite distinguishing Doe where plaintiff argued she did not have to be intended beneficiary of federal funded program to assert claim but that regs granted private COA , there is no requirement plaintiff plead he is intended beneficiary, third party standing for patient discrimination dismissed.		Yes, personal No, patients

1996	Ellis v. Morehouse School of Medicine (N.D. Ga.)	Medical student alleged disparate *treatment* under Title VI due to med school's refusal to provide transcript after dismissal from medical school. Held: Plaintiff failed to establish prima facie case of retaliation and if he did, school's explanation that it does not give transcripts if owe money to school		No

1996	Burks v. City of Philadelphia (E.D. Pa)	Employees brought claim alleging racially discriminatory practices by director of city AIDS program racially discriminated causing harms to intended beneficiaries of AIDS community on basis of race. Held: Dismissed, granting D's motion for summary judgment on this claim because Title VI does not redress employment discrimination unless program purpose = to provide employment. Not here.	Director failed to fund programs, fill vacancies in prison unit serving predominately minority population.	No
1996	Grimes v. Superior Home Health Care of Middle Tennessee, Inc. (M.D. Tenn)	Employee sues to allege dismissal was discrimination. Held Title VI not authorized for employment unless primary objective of fed funds = employment		No

1996	Madison-Hughes v. Shalala (6th Cir.)	Patient and public interest group sue Secy of DHHS alleging Title VI discrimination by failure to collect data and info for Title VI enforcement. Held: Dismissed for lack of subject matter jurisdiction since data collection not mandatory under statute or regulations.		No
1998	Fuller v. Rayburn, (8th Cir.)	African American student sued university for canceling his enrollment when fees unpaid while not canceling enrollment of white students with unpaid fees. Held: Title VI permits recovery of damages for intentional disparate *treatment* and 11th Amendment does not bar.	Three white students with unpaid fees not dismissed thus plaintiff discharged burden to support prima facie case of discrimination and to make pretext a material question of fact.	Yes

2001	LaBlanche v. University of Iowa, College of Medicine (8th Cir.)	Former medical student dismissed, sued alleging disparate *treatment* under Title VI and Iowa Civil Rights Act. Held: Plaintiff failed to show college's non-discriminatory reason for dismissal (her failing grades) was pretext.		No
2002	Marsaw v. Trailblazer Health Enterprises, LLC (S.D. Tex)	Black owned Medicare physical rehab providers sued Secy of HHS and private insurer who acted as Part B Medicare carrier alleging discriminatory reimbursement and other financial activities. Held: Title VI does not apply to programs administered by federal agency	After finding list identifying all Black-owned facilities, Carrier placed these facilities on individualized not electronic review for reimbursement claims; increased denial rate from 2% to 100% and admonished return of list; placed on post payment audit status and charged with overpayment	No

2003	Ali v. University of Mass Med Center (1st Cir.)	African American med school applicant alleges disparate *treatment* while application pending and denying admission to plaintiff. Held: While Plaintiff's allegations made prima facie case, unable to rebut non-discriminatory reason for not admitting Ali who was out-competed by other applicants		No