



Stopping Discrimination Before it Starts: The Impact of Civil Rights Laws on Health Care Disparities- A Medical School Curriculum

Facilitator's Guide

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OVERVIEW

Stopping Discrimination Before It Starts: The Impact of Civil Rights Laws on Health Care Disparities – A Medical School Curriculum is a joint project of the National Consortium for Multicultural Education for Health Professionals (NCME), Stanford University School of Medicine, and the U.S. Department of Health and Human Services (HHS), Office for Civil Rights and the HHS Office of the General Counsel. Using a hypothetical case to encourage participant engagement, this curriculum focuses on racial and ethnic health disparities, cultural competency in medicine, *and* introduces compliance with Title VI of the Civil Rights Act of 1964 to medical students and other students in the health professions.

Our primary objective is to integrate Title VI into medical school curriculums to enable physicians to act as agents for social responsibility in the diverse settings in which they practice. This curriculum ensures that medical students and other students in the health professions understand that some aspects of “culturally competent” care – including access for limited English proficient persons and non-discrimination in health care on the basis of race, color, or national origin – are not only tools for delivering high-quality health care, but also may be legally required.

The National Consortium for Multicultural Education for Health Professionals was formed when the National Institutes of Health, National Heart, Lung and Blood Institute, awarded a five-year grant to a consortium of 18 medical schools around the country for the purpose of developing curricula on cultural competency in medicine. The Consortium has partnered with the HHS Office for Civil Rights and the HHS Office of the General Counsel to develop this curriculum.

Dr. Clarence H. Braddock III, MD, MPH, of Stanford University School of Medicine, directs a coordinating center for NCME. Other medical schools participating in the Consortium include the: Albert Einstein College of Medicine; Baylor College of Medicine; Drexel University; Howard University; Morehouse College; Texas Tech University; State University of New York, Buffalo; University of Alabama, Birmingham; University of California, Los Angeles; University of California, Irvine; University of Chicago; University of Illinois, Chicago; University of Maryland; University of Pennsylvania; University of Rochester; University of Washington; and Wake Forest University.

NCME and the HHS Office for Civil Rights presented this curriculum in November 2007, at the American Association of Medical Colleges’ annual meeting in Washington, DC; in September 2008, at Wake Forest University School of Medicine, in Winston-Salem, North Carolina; and in February 2009, at the HHS Office of Minority Health’s Third National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health, at National Harbor, Maryland.

Goals

After completing this curriculum, participants will be able to:

- Discuss the relevance of Federal civil rights laws to health care practice;
- Describe the current extent of racial and ethnic health disparities;
- Identify and address the potential for discrimination under Title VI of the Civil Rights Act of 1964;
- Apply the law to hypothetical health care scenarios; and
- Understand how the HHS Office for Civil Rights enforces Title VI through investigations and technical assistance to health care providers and entities.

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RECOMMENDATIONS FOR FACILITATORS

This curriculum is intended to be presented by at least one physician and one attorney. You and other members of your institution may organize and lead the presentation of this curriculum independently, or you may request that representatives from the HHS Office for Civil Rights (OCRMail@hhs.gov, 202-260-7180) present this curriculum in partnership with you.

As noted in the PowerPoint presentation, we recommend that after the introductory slides, you play the first six minutes from the “Worlds Apart” video: the “Robert Phillips’ story.” The video, “Worlds Apart: A Four-Part Series on Cross-Cultural Health Care,” was produced by Maren Grainger-Monsen, MD, and Julia Haslett, of the Stanford University Center for Biomedical Ethics. Although we are unable to provide an excerpt in the PowerPoint presentation, the “World’s Apart” video is available from Fanlight Productions (www.fanlight.com, orders@fanlight.com, or 800-937-4113).

We also recommend that you pace the presentation of the medical and legal aspects of the curriculum so that there is ample time for discussion of the Health Disparities Hypothetical and the Questions to Consider at the end of the presentation. We have found that the curriculum is best presented in a threehour time period, with 45 minutes allotted for the discussion of the Health Disparities Hypothetical and the Questions to Consider, although may be presented in a two-hour lecture format. Alternatively, depending upon the needs of your institution, the curriculum may be presented during two 90 minute sessions or three 60 minute sessions.

Although the PowerPoint presentation, this Facilitators’ Guide and the Health Disparities Hypothetical are intended to facilitate the presentation of this curriculum, we have found that the curriculum “comes alive” when you add your own perspective on health disparities from your life experience, medical practice, legal practice, teaching, or research. In addition, we are providing you with an assessment tool to evaluate the effectiveness of your presentation, but it is not necessary for the implementation of this curriculum.

ACKNOWLEDGEMENTS

Stopping Discrimination Before It Starts: The Impact of Civil Rights Laws on Health Care Disparities – A Medical School Curriculum was developed in part by funding from National Institutes of Health, National Heart, Lung and Blood Institute, award# K07 HL079330-03, RFA-HL-04-012, “Integrated Immersive Approaches to Cultural Competence” (2004-9).

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SLIDE 1 NOTES:

“Stopping Discrimination Before It Starts: The Impact of Civil Rights Laws on Health Care Disparities — A Medical School Curriculum”

Talking Points

Welcome to our session, “Stopping Discrimination Before It Starts: The Impact of Civil Rights Laws on Health Care Disparities — A Medical School Curriculum.” This module was created in partnership by members of the National Consortium for Multicultural Education for Health Professionals from Stanford University School of Medicine; the U.S. Department of Health and Human Services (HHS), Office for Civil Rights; and the HHS Office of the General Counsel.

Background information for facilitator

The facilitator will welcome the participants to the session.

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SLIDE 2 NOTES:

“Module Overview”

Talking Points

Today, we will discuss health disparities and discrimination in our health care system. We will focus our attention on one civil rights law, Title VI of the Civil Rights Act of 1964, and you will have an opportunity to see how this law applies to health care settings. We will also discuss the role of physicians, as well as the role of the HHS Office for Civil Rights, in combating discrimination in health care settings.

Our hope is that this presentation will increase your sensitivity and commitment to protecting the civil rights of all patients, regardless of their race, color or national origin.

Background information for facilitator

Facilitator goals for the module:

- To provide opportunities for participants to think about systemic issues resulting in health disparities and opportunities for social change;
- To instill in participants a greater sense of responsibility for the policies and procedures of their health care institutions that may result in health disparities;
- To change participants’ future practice, policy, and decision making regarding issues that may affect health disparities; and
- To inspire participants to inspire others to address health disparities.

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SLIDE 3 NOTES:

“Title VI of the Civil Rights Act of 1964 (Title VI)”

Talking Points

Title VI of the Civil Rights Act of 1964 states: [Facilitator to read slide] “No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” 42 U.S.C. § 2000d.

You may be contemplating a question: “What, if anything does this, Title VI, have to do with physicians in the practicing community?”

Background information for facilitator

The facilitator’s goal is to introduce Title VI to the participants and make them aware of the legal foundations for the workshop.

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SLIDE 4 NOTES:

“How does Title VI apply to health care practice?”

Talking Points

To answer this question, we should start by considering the roles physicians play in their health care practices, institutions, and community organizations. “What are some of these roles?” [Participants should be encouraged to reflect individually or in pairs, then share some thoughts.]

Physicians play a number of roles, including members of quality improvement teams, clinician-educators, community advocates, and hospital board members. In each of these roles, physicians may observe potential Title VI violations.

As leaders in health care organizations, physicians have an obligation to be observant of violations of the law [e.g. draw parallel to abuse prevention laws], and to protect the vulnerable. Physicians have an ethical obligation to support access to medical care for all people; and to be advocates for ALL patients.

Background information for facilitator

The intention of this slide is to demonstrate to participants the critical importance of Title VI in health care practice.

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SLIDE 5 NOTES:

Excerpt from the “Worlds Apart” video: “Robert Phillips’ story”

Talking Points

Robert Phillips is a young man in need of a kidney. For two and a half years he has undergone dialysis, acutely aware of the strain it has taken on his body. Although he is actively involved in his health care, he feels the odds are against him receiving a transplant because of his race. In Dr. Maren Grainger-Monsen’s award-winning documentary, “Worlds Apart,” Robert movingly shares his experiences as a patient, and his concerns about the medical community and its role in perpetuating racial disparities in health care.

Background information for facilitator

At this point, show a segment from “Worlds Apart,” a documentary film and medical education project produced by Maren Grainger-Monsen, M.D. and Julia Haslett.

In the film, Robert, 29 years of age, has end-stage renal disease due to focal sclerosis. After five months on dialysis, he was put on a waiting list for a renal transplant.

[Film: “Worlds Apart: A Four-Part Series on Cross-Cultural Health Care” Produced by Maren Grainger-Monsen, M.D. and Julia Haslett. Available from Fanlight Productions at 1-800-937-4113, www.fanlight.com or by email at orders@fanlight.com (2003)]
<http://medethicsfilms.stanford.edu/worldsapart>

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SLIDE 6 NOTES:

“Reflection”

Talking Points

Let’s take some time to reflect on what we have just seen. Write down your thoughts, responses, or reactions to the issues raised in the video. [Pause for participants to write notes]. When you are ready, let’s share some thoughts that you have written down in response to the film. What were your reactions to Robert Phillips’ perceptions of the treatment he received?

Background information for facilitator

Participants will reflect on the content of the video/case vignette by describing any emotional responses or reactions to issues raised in the video.

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SLIDE 7 NOTES:

“How extensive are health disparities?”

Talking Points

“How extensive are health disparities?”

Background information for facilitator

This is a transition slide.

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SLIDE 8 NOTES:

“Patient perceptions”

Talking Points

- There have been recent reports on patients’ perceptions of racial bias, and how the public perceives how race and ethnicity affect treatment. The National Health Care Disparities Report discussed the results of a random telephone survey in which the patients were asked if they agreed with the following statement, “Race affects my health care.” Over one-sixth, or 17%, of African-American patients agreed with the statement, but only 3% of White patients agreed. [See Agency for Health Care Research and Quality, U.S. Dept. of Health & Human Services, *National Health Care Disparities Report* (2004).]
- The Kaiser Family Foundation conducted a similar study and asked patients and physicians the same question, “How often do you think our health system treats people unfairly based on race or ethnic background?” It is important to note that 29% of the physicians agreed that the health care system treats people unfairly based on race or ethnic background, very or somewhat often; while almost half, or 47% of the non-physicians stated that race or ethnic background plays a role in treatment bias.

[See Kaiser Family Foundation, *National Survey of Physicians Part I: Doctors on Disparities in Medical Care, Highlights and Charts 3-4* (2002) (<http://www.kff.org/minorityhealth/20020321a-index.cfm>).]

Additionally, although it is not shown in this slide, there are also notable differences in how African-American and White physicians responded to the question.

Background information for facilitator

There are gaps between African-American and White patients in their perceptions of physicians’ inter-personal skills and their perceptions regarding how race affects health care.

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SLIDE 9 NOTES (continued):

IOM Report – “Unequal Treatment”:

The report found that access, quantity, and quality of care are unequal for racial and ethnic minority patients, and disparities are associated with higher minority mortality. [*Unequal Treatment: Confronting racial and ethnic disparities in health care.* (Brian D. Smedley et al. eds., 2003)]

Additional information:

According to the Federal government's Centers for Disease Control and Prevention, black babies have higher death rates than white babies. Black women are more than twice as likely as white women to die of cervical cancer. And in 2000, the death rate from heart disease was 29 percent higher among African-Americans than among white adults, and the death rate from stroke was 40 percent higher. [Shankar Vedantam, *The Color of Health Care: Diagnosing Bias in Doctors*, Wash. Post, Aug. 13, 2007, at A03.]

Additional Resources:

The Disparities Solutions Center at Massachusetts General Hospital:
<http://www.massgeneral.org/disparitiessolutions>

Unnatural Causes: Is Equality Making Us Sick? (film) (California Newsreel with Vital Pictures, Inc. 2008) at <http://www.unnaturalcauses.org>

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SLIDE 10 NOTES:

“Health Disparities”

Talking Points

- Here are some different types of racial and ethnic disparities. There are differences in rates of disease, such as prevalence of diabetes. For example, the rates of diabetes in Blacks and American Indians are higher (11.4% and 14.9% respectively) compared to Whites (8.4%).
- There are disproportionate differences in health outcomes. Adjusted for age, stroke deaths are almost 80% higher in Blacks than in Whites.
- There are differences in health care access, such as ease of access to prenatal care.
- There are also differences in treatment. For example, there are differences in the rate of flu shots; fewer Hispanic and Black senior citizens receive shots for the flu than do Whites. Researchers and physicians recognize that health disparities exist and are prevalent.

Background information for facilitator

What are racial and ethnic disparities?

- Differences in rates of disease

Example: The rates of diabetes in Blacks and American Indians are higher (11.4% and 14.9% respectively) as compared to Whites (8.4%), [*National Institute of Diabetes and Digestive and Kidney Diseases. National Diabetes Statistics fact sheet: general information and national estimates on diabetes in the United States, 2003. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, 2003. Rev. ed. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, 2004.*]

- Differences in health outcomes

Example: There are disproportionate differences in health outcomes (e.g. if the rate of death from stroke is almost 80% higher for Blacks than it is for Whites, that would be a disparity). [*Adjusted for age, stroke deaths are almost 80% higher in Blacks than in Whites—DATA2010, the Healthy People 2010 Database, Feb. 2002*]

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SLIDE 10 NOTES (continued):

- Differences in health care access

Example: Minority children have poorer oral health and less access to preventative dental care. [Guidance for the National Health Care Disparities Report. Washington, D.C.: The National Academies Press; 2002.]

- Differences in treatment

Example: Fewer Hispanic and Black senior citizens receive shots for the flu than do Whites, suggesting that there is a disparity in access or in treatment. (*In 2002, influenza vaccination rates for non-institutionalized adults aged 65 years and older: 50% of Blacks and 49% of Hispanics, compared to 68% of Whites. [DATA 2010, the Healthy People 2010 Database, November, 2004 Edition – 09/09/05. <http://www.healthypeople.gov/data/data2010.htm>]*)

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SLIDE 11 NOTES:

“Why do health disparities exist?”

Talking Points

- Now we will look at why health disparities and disparities in care exist.

Background information for facilitator

This is a transition slide.

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SLIDE 12 NOTES:

“Why do health disparities exist?” (continued)

Talking Points

- There are multiple reasons why disparities exist. There are real underlying differences in clinical factors. There are differences in how a disease presents in patients. But, if you recall the IOM *Unequal Treatment* report, some of these factors are accounted for in the disparities research.
- There is a growing industry focusing on pharmaco-genomics which is the study of how an individual's genetic inheritance affects the body's response to drugs. A recent example of an innovation in pharmaco-genomics is BiDil, a recently FDA-approved medication aimed at African-American patients with heart failure, and is derived from a combination of two older medications that was pilot tested only on African-American patients.
- Patients also have varying levels of access to health care, such as lack of insurance, inability to pay, or other institutional barriers to health care. Again, these factors are accounted for in disparities research.
- There are differences in communication strategies, which includes patient and relationship-building strategies, and includes physicians being aware of their patients' health literacy, their cultural background, and in cases where needed, determining their language proficiency to provide adequate care for limited English proficient (LEP) patients. Over the last few years, there have been more studies focusing on improving the patient-physician interaction as a potential tool to decrease health disparities.
- Lastly, there is actual racial bias that leads to significant differences in treatment and outcomes. This will be the focus of our discussion.

Background information for facilitator

[Oddone EZ, Petersen LA, Weinberger M, Freedman J, Kressin NR. Contribution of the Veterans Health Administration in understanding racial disparities in access and utilization of health care: a spirit of inquiry. *Med Care*. Jan 2002;40(1 Suppl):I3-13.]

The slide intends to explain disparities and acknowledge physician bias.

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SLIDE 12 NOTES (continued):

- Kahn JD. BiDil for heart failure in black patients. *Ann Intern Med.* Aug 7 2007;147(3):215; author reply 215-216.
- Bibbins-Domingo K, Fernandez A. BiDil for heart failure in black patients. *Ann Intern Med.* Aug 7 2007;147(3):214-215; author reply 215-216.
- Crawley L. The paradox of race in the Bidil debate. *J Natl Med Assoc.* Jul 007;99(7):821-822.
- Matthews GE. BiDil: primary care physicians first and cardiologist when? *J Natl Med Assoc.* Jun 2007;99(6):697-699; quiz 700.
- Temple R, Stockbridge NL. BiDil for heart failure in black patients: The U.S. Food and Drug Administration perspective. *Ann Intern Med.* Jan 2 2007;146(1):57-62.
- Bibbins-Domingo K, Fernandez A. BiDil for heart failure in black patients: implications of the U.S. Food and Drug Administration approval. *Ann Intern Med.* Jan 2007;146(1):52-56.
- Carmody MS, Anderson JR. BiDil (isosorbide dinitrate and hydralazine): a new fixed-dose combination of two older medications for the treatment of heart failure in black patients. *Cardiol Rev.* Jan-Feb 2007;15(1):46-53.]

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SLIDE 13 NOTES:

“How do physicians contribute to health disparities?”

Talking Points

- Based on the previous slide, how do physicians contribute to disparities?

Background information for facilitator

This is a transition slide.

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SLIDE 14 NOTES:

“Research on provider bias”

Talking Points

- This is an example of just one provocative study that examines true racial and gender bias. In the Schulman study, actors portrayed patients with the same clinical characteristics of coronary risk, type of chest pain, and the results of an exercise stress test, with each video portraying a patient of a different gender and race. Videotapes of the clinical encounters were shown to a group of cardiovascular physicians, who then were asked to make a referral recommendation, an evaluation of personality traits, and an assessment of behaviors attributed to the patients portrayed on the video. The researchers then adjusted for physician assessment of probability and severity of symptoms for a multivariate analysis of predictive variables.

Background information for facilitator

Findings suggest that the race and sex of a patient independently influence how physicians manage chest pain.

Study Design: A computerized survey instrument showed a video with a total of 144 descriptions using combinations of: race (black or white), sex, age, level of coronary risk, type of chest pain, and the results of an exercise stress test. Each physician (n=720) was randomly assigned two trials to assess decisions about management and report patient characteristics, such as likelihood to over-report symptoms, miss follow-ups, participate in treatment, sue for malpractice, comply with therapy, and benefit from revascularization procedure.

Statistical Methods: The study included univariate analyses to assess differences in the physicians' responses when different experimental values are presented. The differences were evaluated with t-tests, ANOVA, and chi-square tests. Multivariable logistic-regression analyses were used to assess the effect of sex and race (decisions for referral). The analysis was done twice: first, to analyze the main effects of race and sex individually; and second, to analyze the effects of race and sex plus a race-sex interaction.

[Schulman KA, Berlin JA, Harless W, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *N Engl J Med.* 1999;340(8):618-626.]

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SLIDE 14 NOTES (cont):

“Patients as Portrayed by Actors in the Video Component of the Survey”

Background information for facilitator

The Schulman study used actors who had similar physical characteristics, with the exception of their race. This slide is intended to illustrate the similarities in the patients. In screen shots, you can see how the patients are portrayed by actors with similar physical characteristics other than race in the video component of the study. Panel A, of the printed study, shows a 55-year-old black woman; Panel B a 55-year-old black man; Panel C a 55-year-old white man; and Panel D a 55-year-old white woman. Each patient wore the same gown and was trained to describe the same symptoms and show a similar facial expression.

[Schulman KA, Berlin JA, Harless W, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *N Engl J Med.* 1999;340(8):618-626.]

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SLIDE 15 NOTES:

“Evidence of provider bias”

Talking Points

Cardiac catheterization referral rates were lower for Black patients and women. Black women had the lowest referral rates, with White men having the highest referral rates. The physicians' perceptions of patients' personal characteristics differed on seven personality traits and behavioral predictions. The physicians rated patients in the scenarios differently across racial and gender lines on the following scales: hostile-friendly, dependent-independent, sad-happy, negative affect-positive affect, worried-indifferent, low SES-high SES, and likeliness to over-report symptoms. The results suggest stereotyped or biased perceptions based on race. White women were perceived to be sadder and more worried than their male counterparts. Black women were thought to be more likely to over-report symptoms, which may account for the lower referral rates. White men were thought to be more likely to sue, and White women were perceived as being more likely to comply with treatment. This study is just one example of physician bias in health care.

Background information for facilitator

[Schulman KA, Berlin JA, Harless W, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *N Engl J Med.* 1999;340(8):618-626.]

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SLIDE 16 NOTES:

“When does racial bias amount to a civil rights violation?”

Talking Points

Now we are going to look at the difference between bias and discrimination.

Background information for facilitator

This is a transition slide.

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SLIDE 17 NOTES:

“Bias and Discrimination”

Talking Points

- We have discussed the various causes of health disparities, such as clinical differences, access to health care, patient-physician interaction, and actual racial bias. We will now take a closer look at both bias and discrimination as a cause of health disparities.
- What is the difference between racial bias and racial bias that amounts to discrimination under the law? Beliefs by themselves are not discriminatory; however, if beliefs affect the quantity or quality of health care provided, then the treatment may amount to discrimination under the law.

Background information for facilitator

Prejudiced beliefs and attitudes, alone are not enough to be considered discrimination. The beliefs and attitudes must result in different treatment to be considered discriminatory.

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SLIDE 18 NOTES:

“Legal Implications of Bias”

Talking Points

- When trust is compromised, the physician may be perceived to not be working in the best interest of the patient, which may lead to patient and group perception of bias in care. When the professional and customary standards of care are not met, there are grounds for malpractice lawsuits.
- _____, will now discuss the historical perspective on disparities in health care prior to the passage of Title VI.

Background information for facilitator

This slide summarizes the work of Crossley, 2003. The facilitator’s goal is to persuade physicians that complying with Title VI will prevent litigation, increase the quality of patient care and makes good business sense.

[Crossley MA. “Infected Judgment: Legal Responses to Physician Bias,” 48 *Villanova Law Review* 195 (2003).]

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SLIDE 19 NOTES:

“What is the history of Title VI?”

Talking Points

Understanding the role of discrimination as a continuing cause of health disparities requires an understanding of the history of health care and race in this country.

This entire session could be devoted to talking only about this complex, important and rarely discussed history, but we have only a few minutes today to do so. With that in mind, let us focus on three concepts.

First, it was not long ago that health care in America was a different world indeed, a world where treatment for African-Americans was by law permitted to be provided (indeed, often required to be provided) in separate, segregated facilities.

Second, it was really the advent of the Medicare program, with its massive and unprecedented Federal funding of health care – along with Title VI – which prohibited such funds from flowing to hospitals that discriminated on the basis of race – that together formed a catalyst that would integrate the nation’s hospitals virtually overnight. [See Title XVIII of the Social Security Act, codified as amended at 42 U.S.C. §§ 1395-1395ccc.]

Finally, the lack of equal access for racial minorities to quality health care today is strongly rooted in the legacy of segregation. Understanding the history of health care and race in this country is therefore critical to utilizing Title VI of the Civil Rights Act of 1964 as an effective tool for raising physician awareness of the role discrimination might play – not only in treating patients, but when fulfilling leadership roles in the community, and when faced with decisions impacting racial minorities’ access to health care.

Our focus in the next few minutes is to summarize how the civil rights struggle in health care between 1948 and 1968 reshaped health care in the United States, and to discuss why it matters.

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SLIDE 19 NOTES (continued):

Background information for facilitator

The facilitator should set the stage for physicians by giving them an overview of the following key concepts:

- (1) Historically, health care in America was entirely segregated.
- (2) Medicare provided – for the first time – Federal funding for health care.
- (3) Title VI of the Civil Rights Act of 1964 tied Federal funding to non-discriminatory practices. This paved the way for integrated health care.

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SLIDE 20 NOTES:

“U.S. Health Care Prior to Title VI”

Talking Points

- In 1948 – not that long ago – health care in the United States was sharply divided along racial lines.
- Jim Crow laws – that is, laws that denied African-Americans their basic civil rights, and required segregation – imposed separate health care accommodations. If communities were not large or affluent enough to afford separate, full-service hospitals, which they often weren't, African-Americans were cared for in basement wards and separate wings, which invariably lacked resources – poorly ventilated, poorly lit – and often without operating rooms.
- In many communities, African-Americans were excluded from the community's hospitals altogether (for example, in Broward County, Florida in the 1940s).
- In Northern urban areas with large concentrations of African-Americans, there was almost as much segregation as in the South. In Chicago, almost all African-Americans went to two historically black hospitals, bypassing hospitals that were much closer in proximity to black neighborhoods.
- The results were tragically predictable, as examples from Preston Reynolds' excellent article “Hospitals and Civil Rights, 1945-1963” illustrate. [See Reynolds, P., Hospitals and Civil Rights, 1945-1963: The case of *Simkins v. Moses H. Cone Memorial Hospital.*, *Ann Intern Med.* 1997;126:898-906.]
- Thus – blocked in both the South and the North from white hospitals in the first half of the 20th century – black physicians developed a separate system. They developed:
 - o Historically black medical schools (for example, Meharry Medical College and Howard University College of Medicine)
 - o Over 220 historically black hospitals
 - o African-American health care professional societies and medical organizations (for example, the National Medical Association and the National Hospital Association).

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SLIDE 20 NOTES (continued)

Background information for facilitator

The facilitator should convey the following key concepts:

- (1) Jim Crow laws imposed separate health care accommodations in the South.
- (2) In Northern urban areas with large concentrations of African-Americans, there was almost as much segregation as the South.
- (3) African-American physicians were often excluded from white hospitals, and adapted by developing a separate system.

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SLIDE 21 NOTES:

“U.S. Health Care Prior to Title VI (continued)”

Talking Points

What was most troubling in 1948 was not only segregation in health care, but also how impossible it seemed that there would ever be any significant change. In most communities, racial integration in hospitals and health care was simply off the radar screen. Integration efforts focused on schools and public accommodations, which seemed easier to achieve. But a confluence of events came together to bring de jure segregation in hospitals (that is, segregation actually sanctioned by the law) to an end.

The Hospital Survey and Construction Act of 1946, [codified as amended at 42 U.S.C. §§ 291] provided Federal matching funds to states for the construction of hospitals that did not discriminate on the basis of race, creed, or color. Sounds promising. But the “Hill-Burton Act,” as it came to be known, also included a provision allowing states to build “separate but equal” facilities. Most southern states proceeded with the construction of racially separate facilities using Federal Hill-Burton Act funds.

IMAGE: Here you see a photo from the original dedication ceremony of a hospital to be built in Alabama, the first hospital to be funded by the Hill-Burton Act. As you can see, there are two foundations being built for two towers. The original “twin towers” were in Atlanta. Grady Memorial hospital – still a part of Atlanta’s skyline – had been planned as an airtight defense of the “separate but equal” doctrine.

The phrase inserted in the Hill Burton Act allowing separate but equal facilities was the only one ever included in Federal legislation in the 20th century that explicitly permitted the use of Federal funds for racially exclusionary services. It proved the perfect vehicle for a successful legal challenge.

Now, while it would appear that such a legal challenge would have been unnecessary by 1954, when the Supreme Court in *Brown v. Board of Education*, [347 U.S. 483, 495 (1954)], overturned the precedent established in *Plessy v. Ferguson*, [163 U.S. 537 (1896)] (which had permitted state laws requiring separate but equal facilities), hospitals were different – they were private institutions, not state actors. That is, at least until the link to Hill Burton was focused upon.

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SLIDE 21 NOTES (continued):

- Hill Burton was not just a Federal funding stream. It required states to work closely with hospitals in developing plans for construction. And in 1963, in *Simkins v. Moses H. Cone Mem'l Hosp.*, [323 F.2d 959 (4th Cir. 1963)], the United States Court of Appeals for the Fourth Circuit held that hospitals accepting Hill-Burton funds were instruments of the state, and that the Act's "separate but equal" provision was unconstitutional under the 14th Amendment. The Supreme Court declined to review the case, which was viewed as implicitly approving the decision.
- *Simkins* is such an important case in this arena that it's worth talking briefly about the facts.
- A patient with an abscessed swollen jaw went to L. Richardson Hospital in Greensboro, North Carolina, which was an all-black facility. However, L. Richardson had a two-week waiting list for a bed. Moses H. Cone Memorial Hospital, the largest and most prestigious facility in Greensboro, allowed black patients on a limited basis but restricted privileges to white physicians and dentists. Since the dentist in *Simkins v.* was African-American, the patient could not access Moses Cone. The Court held that the hospitals, by virtue of their involvement in the state Hill-Burton plan, were indeed instruments of the State. The court struck down the "separate but equal" provision of Hill Burton, finding it unconstitutional.

Background information for facilitator

Key concepts:

- (1) The Hill-Burton Act, [42 U.S.C. §§ 291] enacted in 1946, provided Federal matching funds to states for the construction of hospitals that did not discriminate on the basis of race, creed, or color.
- (2) Hill-Burton allowed states to have "separate but equal" facilities.
- (3) *Brown v. Board of Education* [347 U.S. 483, 495 (1954)], did not open the courtroom door to 14th Amendment equal protection challenges to racial restrictions related to hospitals.
- (4) Most hospitals were private institutions, and therefore courts found their discriminatory acts did not constitute state action.
- (5) However, *Simkins v. Moses H. Cone Mem'l Hosp.* [323 F.2d 959 (4th Cir. 1963)], held that hospitals' close engagement with the state in implementing Hill-Burton rendered the hospitals "instruments of the state," and found the Hill-Burton Act's "separate but equal" provision unconstitutional under the 14th Amendment.

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SLIDE 21 NOTES (continued):

The November 1947 photo displayed on Slide 22 is in the public domain. [U.S. Department of Health and Human Services, National Institutes of Health, National Library of Medicine, *Images from the History of the Public Health Service* (April 27, 1998), available at http://www.nlm.nih.gov/exhibition/phs_history/141.html]

Dedication ceremonies in November 1947, marking the opening of the George H. Lanier Memorial Hospital in Langdale, Alabama. This was the first hospital project approved under the Hospital Survey and Construction Act of 1946, also known as the Hill-Burton Act. The Act authorized Federal grants to the states to survey their hospitals and public health centers, to plan construction of additional facilities, and to assist in their construction. Federal hospital construction funds were allocated on the basis of population and per capita income, the states with the lower income receiving more per capita than the wealthier states. This program has proved to be very valuable in establishing additional hospital facilities and health centers throughout the country, particularly in rural areas.

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SLIDE 22 NOTES:

“U.S. Health Care Prior to Title VI (continued)”

Talking Points

- The new court decision had not taken place in a vacuum, of course. Protests that had been simmering in the 1950s, under the leadership of Dr. Martin Luther King Jr. exploded almost spontaneously into a widespread civil rights grassroots movement in the early 1960s that culminated in the assassination of President John F. Kennedy.
- During the years that the Simkins case was winding its way through the courts, President Kennedy had proposed landmark legislation that outlawed segregation in the schools and in public places.
- President Lyndon Johnson turned the passage of Kennedy’s proposed civil rights bill into the only appropriate way to honor his death.
- During debate of the bill, the other titles, which outlawed segregation in schools, in voting, and in all public accommodations or public places, and prohibited discrimination in employment – received far more attention than Title VI. Title VI, which prohibited Federal funds from being allocated to agencies or organizations that discriminated on the basis of race – was practically a footnote.
- That is because the final piece of the puzzle – the piece that would make Title VI so important – was yet to come. It was the passage of Medicare, which would provide Federal financial support to hospitals for medical care to elderly patients, a cost that previously had gone uncompensated.
- Unlike the Hill Burton Act, which offered time limited matching funds for hospital construction, Medicare represented a profound shift in the financing of medical care in the United States. Combined with Medicaid, it meant that from 1966 forward, the bulk of the income received by most hospitals and their physicians would flow from public sources.
- With one stroke, more than 7,000 hospitals were subject to civil rights regulations set forth in Title VI of the Civil Rights Act.
- In theory at least, hospitals and their physicians would now have to choose between complying with the requirements imposed by Title VI of the Civil Rights Act and thereby assuring their financial health, or not complying, and almost assuring their financial ruin.
- With the passage of Medicare, HHS’ Office of Equal Health Opportunity (OHEO) in the Public Health Service assumed responsibility for certifying Title VI compliance. Staffed by more than 800 persons, most on loan from other agencies, the OHEO rushed to process providers before the July 1966 start date.
- Today, HHS’ Office for Civil Rights has 250 staff nationwide in ten regional offices across the country. All hospitals and other health care institutions who want to participate in the Medicare program are still reviewed for civil rights compliance by OCR – we review and certify several thousand new providers (or providers under new ownership or with new names) for civil rights compliance annually.

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SLIDE 22 NOTES (continued):

- But today, we do much more than certify providers. Today, OCR also enforces Federal laws prohibiting discrimination on the basis of disability, age, sex, and religion – and OCR enforces the HIPAA Privacy Rule.
- OCR also has a strong outreach and technical assistance component – we’ve found that we can achieve a tremendous amount of voluntary compliance by training Federal fund recipients like hospitals about their obligations under the Federal laws. Sometimes that training happens involuntarily, of course, because we receive a complaint that a hospital or other health care provider has discriminated against someone based on race.
- In the next part of this session, you’ll hear more about the laws that OCR uses to investigate complaints, conduct compliance reviews, and negotiate settlement agreements.
- A parting thought. Now that you’ve learned about the merging of social, political, legal, medical and professional forces in the 1960s that culminated in a major transformation in hospitals in the United States, we hope that you will bring to this next part of our discussion a different – broader – perspective. As David Barton Smith – whose seminal work, *Health Care Divided* we are indebted to for today’s discussion of the history of health care and race – states, quoting William Faulkner: “The past is never dead. It’s not even past.” [David Barton Smith, *Health Care Divided: Race and Healing a Nation* 3 – 31 (1999).]

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SLIDE 22 NOTES (continued):

Background information for facilitator

Key concepts:

- (1) In June 1963, President Kennedy introduced a civil rights bill to Congress.
- (2) Following the assassination of President Kennedy, President Johnson made passage of the civil rights bill a priority.
- (3) The bill worked its way through Congress shadowing the Simkins case.
- (4) President Johnson signed the Civil Rights Act into law on July 2, 1964, which included Title VI.
- (5) President Johnson signed Medicare and Medicaid legislation into law on July 30, 1965.
- (6) Medicare and Medicaid meant that the bulk of the income received by most hospitals and physicians would flow from the Federal government.
- (7) These hospitals and physicians, therefore, *must comply with Title VI or risk losing their funding.*

The July 1964 photo displayed on Slide 23 is in the public domain. [National Archives and Records Administration, Lyndon Baines Johnson Library and Museum, *LBJ for Kids!* (2001), available at http://www.lbjlib.utexas.edu/johnson/lbjforkids/civil_photos.shtm]

President Lyndon B. Johnson signs the 1964 Civil Rights Act in the East Room of the White House as Martin Luther King, Jr. and others look on.

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SLIDE 23 NOTES:

“How is Title VI enforced today?”

Talking Points

- _____, will continue with a discussion on the application of Title VI to health care and how it is enforced today.

Background information for facilitator

This is a transition slide.

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SLIDE 24 NOTES:

“Title VI of the Civil Rights Act of 1964 (Title VI)”

Talking Points

- Title VI states that: “No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”
- The significance of Title VI is that it ensures that there is a uniform and permanent nondiscrimination policy in all programs and activities receiving Federal financial assistance.

Background information for facilitator

The facilitator will summarize the legal significance of Title VI of the Civil Rights Act of 1964 (Title VI) to prepare participants for small group discussions requiring the groups to apply Title VI to a hypothetical scenario related to discrimination in health care.

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SLIDE 25 NOTES:

“Who does Title VI protect?”

Talking Points

- Who does Title VI protect? Everyone. Title VI protects persons of every race, color, or national origin.
- What is race? Under Title VI, Black or African-American, White, Asian, Pacific Islander, or American Indian are all protected categories. Race may include physical characteristics, membership in an affinity group or race-linked characteristics, such as sickle cell anemia.
- What is color? Under Title VI, skin color, regardless of race, is a protected category. Thus, a darker-skinned African-American physician could pursue a Title VI suit based on skin color (as opposed to race) if he was passed over for a promotion and another African-American physician was selected because of his lighter skin color.
- What is national origin? National origin pertains to the geographic birthplace of the individual or his or her ancestors. Under Title VI, the protected categories include Hispanic or Latino. National origin and citizenship are distinct concepts. The Title VI protections against national origin discrimination are not limited to citizens, in that Title VI states that “no person” shall be discriminated against on the basis of race, color or national origin.

Background information for facilitator

Key concepts:

- (1) The scope of Title VI is broad – the statute protects persons of every race, color or national origin from unlawful discrimination.
- (2) Race, color and national origin are distinct concepts.
- (3) National origin and citizenship are distinct concepts.

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SLIDE 26 NOTES:

“What entities are covered by Title VI?”

Talking Points

Almost a quarter of all Federal outlays are from the U.S. Department of Health and Human Services (HHS). HHS administers more grant dollars than all other Federal agencies combined. As a result, a large number of health care providers receive Federal financial assistance from HHS and must comply with Title VI. Recipients of HHS Federal financial assistance can include:

- Hospitals, nursing homes, home health agencies, managed care organizations;
- Health research programs;
- Physicians, dentists, hospital social workers; and
- Other health care providers.

Background information for facilitator

Key concepts:

(1) Title VI prohibits discrimination on the basis of race, color, or national origin **in programs and activities that receive Federal financial assistance.**

(2) The HHS Office for Civil Rights investigates programs and activities that receive Federal financial assistance from HHS to determine their compliance with Title VI.

SLIDE 27 NOTES:

“Two Legal Frameworks for Reviewing Title VI Claims”

Talking Points

There are two legal concepts used to review Title VI claims – disparate treatment and disparate impact. These two concepts are critical to understand and remember so that you can identify, address and prevent Title VI violations in the health care settings where you work. For disparate treatment, it is helpful to think about actions based on race. For disparate impact, think about actions that do not obviously look race-based, but do have a disproportionate adverse impact based on race. A policy which harms a specific racial group may be an example of disparate impact.

- **Disparate Treatment** is a form of intentional discrimination. Disparate treatment means that similarly situated persons are treated differently than others because of their race, color or national origin. This would include the use of policies or practices that explicitly classify individuals on the basis of their membership in a particular group.
 - o For example, there would be a valid disparate treatment claim if a medical facility requires all Latino patients to pre-pay for certain lab tests or procedures that are otherwise furnished to other patients without pre-payment.
 - o A second example is OCR’s settlement of a case involving a hospital in New York that had de facto segregated maternity wards; the hospital alleged that placement in a particular maternity ward was based on the patient’s source of payment, although source of payment appeared to be a proxy for race.
- **Disparate Impact** does not require proof of intentional discrimination, but does require that a class of persons be treated less favorably than others. Disparate impact claims arise from allegations that a recipient of Federal financial assistance is violating Title VI regulations by utilizing a neutral policy or practice that has the effect of disproportionately excluding or adversely affecting members of the protected class.
 - o An example would be a disparate impact claim arising from a Federally-funded county department of health providing **evening appointments** for routine medical care at a health clinic located in a predominantly white suburban area, but not providing **evening appointments** for routine medical care at a health clinic located in a predominantly black urban area.
 - o This policy would cause residents of the black area to have a limited number of office hours to choose from when scheduling an appointment, especially if they want to visit the health clinic after normal daytime working hours. This policy – while allegedly not race-based – results in a disproportionate adverse impact on African-Americans.
 - o Once adverse impact is established, OCR must consider whether the recipient of HHS financial assistance – here the county department of health which does not provide evening hours at the health clinic located in the black area – can articulate a “legitimate nondiscriminatory reason” for the challenged policy or action. If so, OCR will determine if the alleged nondiscriminatory reason is a mere pretext for discrimination and if there are “equally effective alternatives” that would create a result with a lesser discriminatory effect.

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SLIDE 27 NOTES (continued):

- o In this example, let's assume that the county department of health provides "staffing costs" as the "legitimate nondiscriminatory reason" for not offering evening appointments at the health clinic located in the black area. If there are equally effective alternatives to resolve the "staffing costs" at issue that would have a lesser discriminatory effect (like having evening hours two days per week at each clinic), then the analysis is complete – it appears that "staffing costs" is mere pretext, and discrimination has occurred. The practice of never offering evening appointments at the health clinic in the black area would violate Title VI. If the reason presented did appear to be a legitimate non-discriminatory reason, but equally effective alternatives exist, a violation would still be found.
- In just a few minutes, we will be applying this four-step disparate impact analysis to a hypothetical. By way of review, the four-step analysis is:
 1. Is there a facially neutral policy or practice?
 2. Does the policy or practice have a disproportionately adverse impact based on race, color or national origin?
 3. Is there a legitimate non-discriminatory reason for the policy or practice, or is the reason presented a mere "pretext" for discrimination?
 4. If a legitimate non-discriminatory reason is presented, are there "equally effective alternatives" to the policy?

Background information for facilitator

The facilitator will explain the difference between the disparate treatment theory of discrimination and the disparate impact theory of discrimination so that the participants learn to identify, address, and prevent Title VI violations in health care settings.

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SLIDE 28 NOTES:

“Unlawful Discrimination under Title VI”

Talking Points

So how does Title VI classify or describe the way that discrimination can occur? You’ll see that the concepts in the law are responsive to the circumstances in 1964, when Title VI and its implementing regulations were written. At that point in time, the problems were due to blatant race discrimination, outright denials of services, restrictions on services, or services that could only be provided in a different, segregated place. Thus, the Title VI Regulations state that:

Recipients of Federal financial assistance may not on the basis of race, color or national origin:

- **Deny or restrict an individual’s enjoyment of a service, aid or benefit under the program;**
- **Provide a benefit which is different or provided in a different manner;**
- **Subject an individual to segregation or separate treatment.**

[45 C.F.R. § 80.3(b)]

Background information for facilitator

The facilitator will provide examples of unlawful discrimination under Title VI so that the students learn to identify, address, and prevent Title VI violations in health care settings.

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SLIDE 29 NOTES:

“Unlawful Discrimination under Title VI (continued)”

Talking Points

Recipients of Federal financial assistance may not on the basis of race, color or national origin:

- **Treat an individual differently in determining eligibility;**
- **Deny an individual an opportunity to participate in the program (including as an employee); or**
- **Deny an individual an opportunity to participate on a planning or advisory board.**

[45 C.F.R. § 80.3(b)]

Disparate Treatment

- Even though the text of Title VI was written to address the circumstances of 1964, Title VI violations certainly occur today. In recent years, OCR has addressed a variety of disparate treatment cases.
- For example, OCR has investigated allegations that qualified minorities have applied for membership on a hospital advisory board and have not been selected because of their race or national origin.
- In a similar vein, OCR has investigated an African-American physician’s allegation that on the basis of race, he was denied staff privileges at a hospital receiving Federal funds; and thereby was excluded from participation in a Federally funded program;
- In addition, OCR has reached a settlement with a national pharmacy chain that had a franchise which repeatedly refused to fill the prescription of an African-American Medicaid recipient. As part of the settlement, the chain apologized to the victim, posted notices of the company’s non-discrimination policy in stores nationwide, and posted the same notice in an advertising circular that reached 25 million people.

Disparate Impact

- An example of a disparate impact claim arose when OCR investigated a complaint alleging that racial segregation would be the result of a hospital corporation’s plan to modernize one hospital in an urban black area; close two hospitals in urban black areas; and build a new hospital in a suburban white area. The complainants alleged that as a result of the plan, the downtown hospital and the suburban hospital would become racially segregated. OCR negotiated a voluntary agreement with the hospital corporation who agreed, among other things, to provide transportation for the (mostly black) downtown residents to the suburban hospital and for the (mostly white) suburban residents to the downtown hospital.

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SLIDE 29 NOTES (continued):

Background information for facilitator

The facilitator will provide actual examples of unlawful discrimination under Title VI.

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SLIDE 30 NOTES:

“Title VI and Limited English Proficient (LEP) Persons”

Talking Points

- An LEP individual is a person whose primary language is not English and who has a limited ability to read, write, speak or understand English.
- Title VI and its implementing regulations prohibit conduct that has a disproportionate adverse effect on the basis of national origin. Failure to provide LEP individuals meaningful access may constitute discrimination.
- Health care providers may be required to provide language access services at no cost if necessary to ensure that persons are not discriminated against on the basis of national origin.

Background information for facilitator

The facilitator will explain that in some situations, health care providers must take reasonable steps to provide meaningful access to Limited English Proficient (LEP) persons in their program, activities and services.

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SLIDE 31 NOTES:

“Examples of Language Access Services”

Talking Points

Health care organizations may provide meaningful access to LEP persons by establishing language access services. These services may include:

- Bilingual staff members
- Contract interpreters
- Telephonic interpreters or language lines
- Videoconferencing interpretation
- Translated materials

For more information about Title VI’s prohibition against national origin discrimination and health care providers obligations to provide language access services, visit OCR’s webpage at:
<http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/index.html>

Background information for facilitator

The facilitator will give examples of language access services.

OCR issued its “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” in August 2003. [Federal Register / Vol. 68, No. 153 / Friday, August 8, 2003, pp. 47311-47323, <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>]

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SLIDE 32 NOTES:

“OCR’s Enforcement Responsibilities”

Talking Points

The HHS Office for Civil Rights (“OCR”) enforces:

- o Laws that prohibit discrimination on the basis of race, color, national origin, disability, age, sex, and religion by recipients of Federal financial assistance from HHS; and
- o The Privacy Rule under the Health Insurance Portability and Accountability Act (“HIPAA”) that protects health information from improper use and disclosure.

Background information for facilitator

The facilitator will explain HHS OCR’s enforcement responsibilities.

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SLIDE 33 NOTES:

“OCR’s Enforcement and Responsibilities (continued)”

Talking Points

- OCR’s responsibilities include:
 - investigating complaints from the public;
 - conducting compliance reviews of health care facilities;
 - securing voluntary corrective action; and
 - initiating enforcement proceedings.

- OCR provides technical assistance to health care providers and entities to promote compliance with the law.

- OCR conducts public outreach to educate consumers about their rights.

For more information and to contact OCR visit: <http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html>

Background information for facilitator

The facilitator will provide the participants with information on how to file a complaint with OCR or contact OCR to receive technical assistance.

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SLIDE 34 NOTES:

“Why should physicians be concerned about Title VI?”

Talking Points

Now _____, will discuss physician roles in health care and the domains of social responsibility.

Background information for facilitator

This is a transition slide.

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SLIDE 35 NOTES:

“Physician Roles in Health Care”

Talking Points

- At different points in your career, you may find yourself in private practice, community practice or working as part of a managed care organization.
- You also may find yourself handling administrative responsibilities as a board member of a hospital, health clinic, or community based organization.
- Physicians may also devote their careers to teaching or research.
- In these roles, you are likely to have the opportunity to:
 - o Seek changes in the law to advance the best interests of the patient;
 - o Be an advocate for the patient;
 - o Support access to medical care for all people; and
 - o Contribute to the improvement of the community and the betterment of public health.

[American Medical Association, Principles of Medical Ethics (2001), available at <http://www.ama-assn.org/ama/pub/category/2512.html>]

Background information for facilitator

Why should physicians be concerned about Title VI? Because Title VI affects them, their patients and their practice environments.

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SLIDE 36 NOTES:

“Social Responsibility”

Talking Points

- Physicians play different roles in our communities and society, yet there is a common ethical obligation to administer excellent care for the greater good.
- The “public profession of values” allow physicians to be part of a dynamic process of bringing in the expertise and experience of colleagues when they care for their patients.
- Physicians also negotiate medical values with societal values. Physicians “promote systems of care” by ensuring that patients and underserved populations have access to care. They also address the rising cost of care.
- Another aspect of physicians’ social responsibility is advocacy. Physicians act as advocates by addressing socioeconomic factors associated with health outcomes, by raising awareness among patients and colleagues about pressing issues, by participating in public advocacy campaigns, and by working with other health care providers, community workers, and public policy advocates to improve systems of care.

Background information for facilitator

Professionalism [Wynia MK, Latham SR, Kao AC, Berg JW, Emanuel LL. Medical professionalism in society. *N Engl J Med.* 1999;341(21):1612-1616.]

- o Devotion to Medical Service includes the goals of individual and public health above all other goals. A devotion to providing health care.
- o Public Profession of Values: MDs to speak out about their values, public to hear about physician’s commitment to standards, allows for MDs to be part of dynamic process by bringing in expertise and experience to care for patients
- o Negotiation regarding professional values and other social values: balance medical values with societal values

Promote systems of care [Gruen RL, Pearson SD, Brennan TA. Physician-citizens – public roles and professional obligations. *JAMA.* 2004;291(1):94-98.]

- o Ensure patients have access to care
- o Address the rising cost of health care

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SLIDE 36 NOTES (continued):

Advocacy [Gruen RL, Campbell EG, Blumenthal D. Public roles of US physicians: community participation, political involvement, and collective advocacy. *JAMA*. 2006;296(20):2467-2475.]

- o Involvement in addressing SES factors associated with poor health outcomes
- o Participate in public advocacy campaigns

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SLIDE 37 NOTES:

“Domains of Physician Responsibility”

Talking Points

- Professional societies, such as the American Medical Association, recently have urged physicians to undertake a greater role in the public arena, challenging the traditional notion of the physician as only directly providing direct care to his or her patients.
- Physicians should still provide competent medical care and maintain good relationships with their patients. But physicians also should ensure proper access to care, such as requesting interpreter services when necessary. In addition, physicians should engage in discussions about public policy directly relating to social influences on health, such as immunizations.
- Health care scholars have argued that physicians have an ethical obligation to undertake roles with greater potential for impact in the larger world. For example, in his seminal work on public roles and professional obligations, Gruen describes physician-citizens engaging in local and global advocacy that impact socioeconomic influences on health.

Background information for facilitator

This slide is intended to invite participants to consider their role(s) in a broader sense, to promote advocacy beyond the physician’s office setting.

[Gruen RL, Pearson SD, Brennan TA. Physician-citizens – public roles and professional obligations. *JAMA*. 2004;291(1):94-98.

Gruen RL, Campbell EG, Blumenthal D. Public roles of US physicians: community participation, political involvement, and collective advocacy. *JAMA*. 2006;296(20):2467-2475.

Wynia MK, Latham SR, Kao AC, Berg JW, Emanuel LL. Medical professionalism in society. *N Engl J Med*. 1999;341(21):1612-1616.]

Professional obligations include:

- Physicians have a core responsibility to provide high-quality care and maintain a good relationship with their patients to reduce the burden of illness
- An additional professional obligation is to ensure proper access to care or systemic characteristics that have a direct effect on care, such as insurance coverage, availability of after-hours care, geographic distribution of services, and interpreter services.
- The last professional obligation a physician has is to participate in discussions around public policy that have a direct effect on social influences in health, such as immunizations, smoking cessation, usage of bicycle helmets, etc. The professional obligation domains often have a direct impact on patients’ lives. Society also expects physicians to articulate a public policy position, considering that SES factors are most directly associated with poor patient health outcomes.

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SLIDE 37 NOTES (continued):

Professional aspirations include:

- Beyond professional obligations, physicians have professional aspirations that go beyond the scope of direct health factors. The purpose of the aspirations domain is to promote physicians as effective solutions to the problem, and to promote participation in public-interest projects. For example, consider local as well as global advocacy. Local advocacy includes advocating for education policy and information about the exposure to environmental hazards. Global advocacy includes advocating for the distribution of resources, knowledge, and opportunities.

Principles of medical ethics

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Principles of medical ethics

1. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
2. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
4. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
5. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care

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SLIDE 37 NOTES (continued)

7. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
8. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
9. A physician shall support access to medical care for all people.

[American Medical Association, Principles of Medical Ethics (2001), available at <http://www.ama-assn.org/ama/pub/category/2512.html>]

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SLIDE 38 NOTES:

“Examples of the Physician’s Roles & Responsibilities”

Talking Points

- Here are some examples of physician’s roles and how they relate to patient care, access to care, direct and broad SES issues, and lastly, global health influences.
- Besides being a health care provider and educator, physicians’ professional obligations can include planning community clinics, participating in quality improvement teams and hospital boards, engaging in global advocacy, and voting in elections.

Background information for facilitator

- This slide provides examples of the physician’s potential roles and responsibilities.

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SLIDE 39 NOTES:

“Analysis of hypothetical cases to identify health disparities and potential Title VI violations”

Talking Points

- In a few moments, we will discuss a hypothetical case and identify potential Title VI violations. Before we discuss the hypothetical, let’s review our “Questions for Analysis.”

Background information for facilitator

This is a transition slide.

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SLIDE 40 NOTES:

“Questions for Analysis of the Hypothetical”

Talking Points

To determine whether there has been **disparate treatment**, we ask the following questions:

- Was the patient a member of a protected class?
- Did the patient apply for or seek services from a Federally assisted health care provider?
- Was the patient eligible to receive the services?
- Was the patient denied services or provided services of a lower quality or quantity?
- Did the Federally assisted health care provider grant services of a higher quality or quantity to patients of a different race, color or national origin?

To determine whether there has been **disparate impact**, we ask the following questions:

- Is the policy or practice neutral on its face?
- Does the policy have a disproportionate adverse impact on the basis of race, color or national origin?
- Is there a legitimate, nondiscriminatory objective for the challenged action?
- Are there any “equally effective alternatives” that would further that objective with less disproportionate adverse impact?

Background information for facilitator

The facilitator’s goal is to review the analysis with the participants before initiating the discussion of the hypothetical.

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SLIDE 41 NOTES:

“Small and Large Group Discussions”

Talking Points

- At this juncture, we are going to provide you with a handout that sets forth a hypothetical situation. You will review the hypothetical situation and determine whether Title VI violations may have occurred.
- Earlier in today’s session, you heard the very personal and moving perspective of an African-American patient on dialysis. He appeared to be well-educated and of middle-class income. He seemed depressed about the prospect of ongoing dialysis and, described indirectly at least, what he viewed as possible racial bias in the organ transplant wait list system.
- We are now going to examine another fact scenario involving a hypothetical patient with end stage renal disease to see if we can bring issues of health disparities – especially those potentially actionable under Title VI – into sharper focus. Each of you should have a handout on OCR letterhead labeled “End Stage Renal Disease Hypothetical.”
- We are going to divide you into small groups to discuss this case, but first let’s lay the foundation. You are a practicing physician who is on the ethical review board of an advocacy organization which works on behalf of low-income and minority persons in the health care arena. The organization asks you to consider the following set of facts which have come to its attention via a complaint that it has started investigating.
- Daryll Jackson is a 42-year-old African-American male with low income and low education levels. He develops end stage renal disease (ESRD). Following his diagnosis, Mr. Jackson is referred to the dialysis center nearest his home in a densely populated, low-income urban area.
- Once Mr. Jackson is started on dialysis, the center’s nephrologist and social worker, along with the nursing personnel and technician, talk briefly with Mr. Jackson about treatment options. The notes in the file indicate that Mr. Jackson is not interested in pursuing the option of obtaining a kidney transplant.
- After four years on dialysis, Mr. Jackson is still not on the waiting list for a kidney transplant. Instead, he still undergoes dialysis three days a week.
- When Mr. Jackson learns from a newspaper article that the experience of patients in a nearby wealthy county, most of whom are Caucasian, is very different, he files a complaint with the advocacy organization listed in the article. In the complaint, Mr. Jackson alleges that he was discriminated against on the basis of race because he has not yet been placed on a waiting list for a kidney transplant.
- We will now hear four perspectives on what happened in this case. [Facilitator turns to four “actors”.]

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SLIDE 41 NOTES (continued):

- First, we will hear from the patient’s physician. [Physician script is read by participant.]
- Next, we will hear from the dialysis center nurse. [Nurse script is read by participant.]
- Now, we will hear from the patient. [Patient script is read by participant.]
- Finally, the dialysis center chain administrator. [Administrator script is read by participant.]
- Now that you’ve heard four different viewpoints, we’re going to ask you to apply Title VI to the fact pattern.

Background information for facilitator

Set the stage for students to apply Title VI to a hypothetical situation. Per earlier note to facilitator, you will need to select four “actors” to play the part in the hypothetical scenario.

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SLIDE 42 NOTES:

“End Stage Renal Disease Hypothetical: Analysis”

Talking Points

- **Group #1 Assignment:** Please apply Title VI of the Civil Rights Act of 1964 to the fact pattern. Identify any potential discrimination that appears to be “disparate treatment” – that is, an action that was based on race, color or national origin.
- **Group #2 Assignment:** Please apply Title VI of the Civil Rights Act of 1964 to the fact pattern. Identify any potential discrimination that appears to be “disparate impact” – a policy or practice that is neutral on its face but has a disproportionate adverse impact on persons based on race, color or national origin.
- For both groups, putting aside the question of whether potential Title VI violations exist, please also consider actions the recipient could take that would increase access for minorities to the recipient’s services, aids or benefits.

Background information for facilitator

This slide presents the questions the participants are to discuss in their small group discussion session. This slide should also be placed on the screen during the large group discussion.

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SLIDE 43 NOTES:

“ESRD Case #1: Disparate Treatment Analysis”

Talking Points

- Do the facts indicate that Mr. Jackson was treated differently by the dialysis center based on race? How?
- In the large group discussion, the spokesperson for Small Group #1 should raise the influence of assumptions – some apparently race-based – upon the doctor’s and nurse’s understanding of Mr. Jackson’s wishes regarding transplant, and upon their own decision-making regarding raising the option over time on multiple occasions. For example:
 - The doctor’s statement that many African-American patients do not choose organ transplant, and how that statement, even if true, might have impacted the doctor’s understanding of Mr. Jackson’s lack of desire to pursue the transplant option.
 - The doctor’s assumption regarding the likelihood that Mr. Jackson would be non-compliant with transplant aftercare (e.g., taking medications), possibly based in part upon a stereotype regarding non-compliance by African-American patients. The doctor admits that this factor “may be another reason why our dialysis center team didn’t pursue the transplant option with Mr. Jackson more vigorously.”
 - The doctor’s assumption that the transplant center would rank Mr. Jackson low on the eligibility scale based on the possibly unfounded conclusion that Mr. Jackson could not pay for aftercare following a kidney transplant.
 - The doctor’s conclusion that a patient who appears unable to independently navigate the system is not a good candidate for transplant.
 - The nurse’s assumption regarding the quality of family and community support available to Mr. Jackson.
 - The nurse’s assumption regarding Mr. Jackson’s family’s unwillingness to donate, and her assumption regarding the role of Mr. Jackson’s brother’s religious beliefs upon Mr. Jackson’s desire to pursue the transplant option.
 - The nurse’s seemingly unfounded assumption that Mr. Jackson had some history of drug abuse.
 - The nurse’s remark about blacks not donating organs at the same rate as whites, and how that statement, even if true, might have impacted the nurse’s approach to Mr. Jackson.

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SLIDE 44 NOTES (continued):

- Questions for discussion:
 - o Do these assumptions appear to be race-based?
 - o Do they appear to have influenced the doctor and nurse's interpretation of Mr. Jackson's response when transplantation was raised at the beginning of his dialysis treatment?
 - o Could the assumptions the dialysis team brought to the pre-transplant work-up have made them hear Mr. Jackson's initial dislike of the transplant option as total rejection?
 - o Could the assumptions have colored the dialysis team's decision not to raise the transplant option again?
- It does look like the dialysis center team – both the doctor and the nurse - may have treated Mr. Jackson differently based on race in determining his eligibility for being referred for evaluation for a kidney transplant, and this may have impacted their decision not to pursue the transplant option further with him.

Background information for facilitator

The facilitator should generate discussion about all possible disparate treatment issues.

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SLIDE 44 NOTES:

“ESRD Case #2: Disparate Impact Analysis”

Talking Points

- Do the facts indicate that the Dialysis Center had neutral policies that disproportionately adversely impact persons based on race?
- Let’s take just one of the legal issues identified by the groups during the discussion – the issue of whether the dialysis center’s policies and procedures involving communication with patients regarding the organ transplant option discriminate on the basis of race – and walk through the disparate impact analysis.
- Are these policies or procedures – particularly the policy requiring only one-time discussion of the transplant option – neutral on their face?
 - **Answer:** *The dialysis center chain’s policy provides that once a patient rejects the transplant option, no further discussion need be scheduled unless the patient so requests does not appear to be race-based. The dialysis center chain’s practice of not providing easy to understand, easy to access information about the transplant option and necessary steps towards transplantation, and lack of a staff person to follow through with patients on the transplant option also does not appear to be based on race.*
- Do the policies have a disproportionate adverse impact on the basis of race, color or national origin?
 - **Answer:** *While in an actual case, statistical analysis would be required, the policies could possibly have a disproportionate impact on the basis of race. If we postulate that in this geographic area, a disproportionate percentage of persons with lower health literacy levels are minorities, it might be possible to show disproportionate impact. Whether the impact could be established as adverse is trickier than it would appear. While from a common-sense perspective, it would certainly seem that persons with lower health literacy levels would be adversely impacted by policies and procedures which do not assist them in understanding their medical options, and in navigating the system, it might be quite difficult to prove a causal connection. In a real case, we would have to establish a direct causal connection between policies and practices that do a poor job of teaching about the transplantation option and patients not ending up on the waiting list. For purposes of this discussion, however, let’s postulate that we can prove such a causal connection, so that “adverse disproportionate impact” is established and we can complete the 4-step disparate impact analysis.*
- Has the recipient articulated a legitimate, nondiscriminatory objective for the challenged actions, or does the reason proffered appear to be mere pretext?
 - **Answer:** *The Dialysis Center chain points to “administrative convenience” and “customer preference” as the reasons for the policy requiring only one-time discussion of the transplant option. These reasons appear to border on pretext, if only because the dialysis center stands to gain by maintaining more “customers” – it may even be said that a conflict of interest exists for these centers. Further, with respect to “administrative convenience,” repeated discussion of the transplant option does not seem to be an onerous burden for the staff. With respect to the lack of easy to understand materials and staff assigned to follow up with patients on the transplant option, the Dialysis Center chain argues that it is financially infeasible to provide better materials or to assign individual staff to conduct follow up.*

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SLIDE 44 NOTES (continued):

- Are there equally effective alternatives that could further the expressed objective with less disproportionate impact?
 - **Answer:** *It does seem that there are some equally effective alternatives that could be considered. For example, the Dialysis Center chain could mass produce a simple video which sets out the transplant process that patients could watch during dialysis; the Dialysis Center chain could establish automatic prompts for quarterly discussion of the transplant option to ensure circumstances or views have not changed, or to answer questions, e.g.*

- Additional Possible Discussion Points:

- More assistance at dialysis centers regarding the transplant option.

- Better dissemination of more effective informational materials.

- Require one-on-one conversations on a quarterly basis in which patients are encouraged to undergo evaluation.

- Improved case management, where dialysis social workers and financial advisors might assist patients in taking the first steps of this complex process.

- Dialysis center staff could also be trained to understand minority health barriers, in order to more effectively assist patients who are non-compliant with diet, medication or dialysis treatment.

- Steps should be taken to ensure that limited English proficient patients can understand these materials and instructions.

Background information for facilitator

The goal of this slide is to generate discussion about possible disparate impact issues.

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SLIDE 45 NOTES:

“ESRD Hypothetical: Increasing Access”

Talking Points

Title VI aside, what actions could the Dialysis Center chain take to increase access for minorities to the Centers’ services, aids or benefits?

- More effective outreach materials about the transplant option.
 - o The Center could make available culturally appropriate brochures – written at the patient’s health literacy level.
 - o This information could also be provided via videos, which could be viewed by patients while undergoing dialysis.
 - o Review of the transplant evaluation process to prevent cultural bias against poor and/or minority patients.
 - o The Center could develop standard criteria for transplant candidacy, which would reduce the possibility that bias would play a part in the transplant wait list placement decision.
 - o In three studies by Alexander and Sehgal that speak to the steps of transplant evaluation, the “pre-transplant workup” is identified as the point at which African-American patients often drop out of the process. In their 1998 paper, the authors note: “Our findings also highlight the role of the pretransplant workup which acts as a barrier among all three [investigated] subgroups, blacks, women and the poor. The importance of this step has not previously been appreciated.” [Alexander GC, Sehgal AR. Barriers to cadaveric renal transplantation among blacks, women, and the poor. *JAMA* 1998;280:1148-1152.] Inconsistent standards for consideration and subjective psycho-social criteria for acceptance may create a disadvantage for low-income minority candidates.

What other actions could help address health disparities among people with ESRD?

- Better access to care for the underinsured or uninsured.
 - o Low-income minorities are more likely to be underinsured or uninsured, and less likely to have a regular source of preventative and primary care. Early screening and treatment for hypertension from an early age can prevent or delay kidney failure among individuals who may not otherwise be aware of their health problems until emergency intervention is necessary. The first step in addressing racial disparities among people with ESRD lies in addressing the difficulties which this population faces in accessing affordable preventative health care.

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SLIDE 45 NOTES (continued):

- Broader and more effective health education.
 - o Health education, with an emphasis on diet and exercise, the need for disease prevention through regular health exams and screening, and compliance in treating hypertension and diabetes is critical. Young people should be aware of these issues early in their lives through exposure in the schools; churches and community-based organizations are also excellent partners for health outreach. Many relevant organizations, including the American Kidney Fund, the National Association of Minority Nephrologists, the National Medical Association, and the Minority Organ Tissue Transplant Program, could expand projects along these lines.
 - o Development and dissemination of clear, simple and culturally appropriate health information, in multi-lingual written and video format, about the consequences of late diagnosis and inadequate care for diabetes and hypertension.
 - o Health care professionals and physicians need to take more time with their patients to explain these issues one-on-one.
- Effective outreach materials regarding the advantages of early wait listing and multiple wait listing.
 - o In a best case scenario, diagnosis of chronic kidney disease, discussion of the transplant option, and referral to a transplant center all take place before dialysis is necessary. However, early and multiple wait listing may increase racial disparities by giving an advantage to those patients who receive early diagnosis.
 - o Developing outreach materials that educate vulnerable populations regarding the availability and advantages of early and multiple wait listing could be an important first step toward correcting some of the current disparities in the organ allocation system. [See Alexander and Sehgal at 1148 - 52.]

Background information for facilitator

The facilitator should encourage the physicians to think creatively about actions the Dialysis Center chain could take to address health disparities among people with ESRD.

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SLIDE 46 NOTES:

“Module Summary”

Talking Points

These were our goals:

- Discuss the relevance of Civil Rights law to health care practice
- Describe the current extent of health disparities
- Identify and address discrimination under Title VI of the Civil Rights Act of 1964
- Apply the law to a hypothetical health care scenario
- Understand how the HHS Office for Civil Rights enforces Title VI through investigations and technical assistance to health care providers and entities

Background information for facilitator

The facilitator will review the module and encourage a brief discussion between the participants.

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SLIDE 47 NOTES:

“Questions to Consider”

Talking Points

We developed this presentation to help you prevent health care discrimination. Before we leave, think about the following questions:

- Do you feel empowered to address national origin or racial bias?
- What will you do to learn more about providing health care that reduces disparities?

Background information for facilitator

The facilitator will encourage the participants to address national origin and racial bias as they progress in their careers.

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SLIDE 48 NOTES:

“Questions to Consider (continued)”

Talking Points

- Does your organization provide services of a higher quality or quantity to majority patients in comparison to minority patients?

For example:

- o Do your facilities in minority areas have comparable specialty clinics, services, and hours of operation, when compared to your facilities in majority areas?
- o Does your organization provide comparable services to Medicaid recipients and non-Medicaid recipients?
- o Does your organization provide effective language access services to LEP individuals?
- o Has your organization developed and implemented initiatives to address health disparities?
- o Has your organization developed nondiscrimination policies and complaint procedures and distributed them to the public?
- o Does your organization advise patients that they may file a complaint with the HHS Office for Civil Rights?

Background information for facilitator

The facilitator will encourage the participants to address national origin and racial bias as they progress in their careers.

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SLIDE 49 NOTES:

Resources

- National Consortium for Multicultural Education for Health Professionals:
<http://culturalmeded.stanford.edu>
- HHS Office for Civil Rights: <http://www.hhs.gov/ocr>
- HHS Health Resources and Services Administration, “Unified Health Communication 101: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency (LEP)” (on-line course) <http://www.hrsa.gov/healthliteracy/training.htm>
- HHS Office of Minority Health: <http://www.omhrc.gov> “A Physician’s Practical Guide to Culturally Competent Care” (on-line course); “Health Care Language Services Implementation Guide” (web-based interactive planning tool) <http://www.thinkculturalhealth.org>
- Cultural Competence Online for Medical Practice (CCOMP), “A Clinician’s Guide to Reduce Cardiovascular Disparities” (on-line course) <http://www.c-comp.org>
- Federal Interagency Working Group on LEP: <http://www.lep.gov>

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SLIDE 50 NOTES:

Acknowledgements

- Medical Education Research Group at Stanford University School of Medicine
- National Consortium for Multicultural Education for Health Professionals (NCME)
<http://culturalmeded.stanford.edu>
- U.S. Department of Health and Human Services, Office for Civil Rights
<http://hhs.gov/ocr/>
- U.S. Department of Health and Human Services, Office of the General Counsel
<http://hhs.gov/ogc/>
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Appendix A: Post-Workshop Assessment

Please rate the following (circle)	Low	—————			High
1. How satisfied were you with the workshop?	1	2	3	4	5
2. Please rate the impact of this workshop on increasing your knowledge about:					
2a. Health disparities?	1	2	3	4	5
2b. Healthcare disparities?	1	2	3	4	5
2c. Title VI of the Civil Rights Act of 1964?	1	2	3	4	5
2d. The Office for Civil Rights?	1	2	3	4	5
3. Please rate the impact of this workshop on changing your attitudes about physicians' and other health professionals' roles to act as agents of social responsibility?					
	1	2	3	4	5
4. Please rate the impact of this workshop on increasing your skill set and capabilities of:					
4a. Identifying Title VI violations:	1	2	3	4	5
4b. Preventing Title VI violations:	1	2	3	4	5
4c. Addressing Title VI violations:	1	2	3	4	5
5. Please rate the impact of this workshop on your:					
5a. Likelihood of considering Title VI of the Civil Rights Act in your practice, educational setting, home institution, and civic activities:					
	1	2	3	4	5
5b. Likelihood of teaching others about Title VI of the Civil Rights Act and the U.S. Department of Health and Human Services, Office for Civil Rights:					
	1	2	3	4	5

Free form response (feel free to continue on the back side of this paper):

6. Which portion of the workshop impacted you the most?