Racism and Health Care in America: Legal Responses to Racial Disparities in the Allocation of Kidneys

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RACISM AND HEALTH CARE IN AMERICA: LEGAL RESPONSES TO RACIAL DISPARITIES IN THE ALLOCATION OF KIDNEYS

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Abstract: African Americans have long been subjected to racism within the health care sector of the United States. During earlier eras of American history, including the pre-Civil War, Reconstruction and Jim Crow time periods, blatant racism in the health care sector was prevalent. Following the Civil Rights Movement of the 1960s, more overt forms of racism dissipated. Now, at the dawn of the twenty-first century, racism within the health care industry manifests itself in more subtle forms. A modern day example of the abominable and often governmentally sanctioned health care that African Americans receive is racial discrimination in the allocation of transplantable kidneys. Despite having a greater incidence of kidney failure than European Americans, African Americans are less likely to be the recipients of transplantable kidneys and spend considerably longer periods of time on kidney allocation waiting lists than European Americans. This Note proposes and analyzes various responses to disparities in kidney allocation on the basis of race including public education, organ donation publicity campaigns, presumed consent to donation laws, the creation of criteria for placement on an United Network for Organ Sharing kidney allocation waiting list, alteration of kidney allocation guidelines, and litigation under both the Equal Protection Clause of the United States Constitution and Title VI of the Civil Rights of 1964.

INTRODUCTION

The health care sector of American society is far from immune to social injustice and the various forms of inequality that negatively impact other societal systems.1 The United States health care industry has been and continues to be plagued by racism.2 During the pre-Civil

1 See discussion infra Part I.C and notes 58-127.
2 See discussion infra Part I and notes 16-127.
War, Reconstruction and Jim Crow eras of American history, overt racism within the medical sphere was common.\(^3\) After the Civil Rights Movement of the 1960s, segregation and some of the more blatant manifestations of racism dissipated.\(^4\) More subtle forms of racism, however, continue to pervade the health care industry.\(^5\)

A modern-day example of the abominable and often governmentally sanctioned health care that African Americans have historically received is racial discrimination in the allocation of kidneys for transplantation.\(^6\) Statistical data reflects sharp disparities in kidney allocation on the basis of race.\(^7\) This Note addresses the issue of racial disparity in the allocation of transplantable kidneys and offers possible legal solutions to this problem.

Part I of this Note provides the reader with an overview of race discrimination within the American health care system.\(^8\) It outlines racism in health care during various historical periods such as the pre-Civil War, Reconstruction and Jim Crow eras.\(^9\) Additionally, it identifies present-day racial inequalities within the health care industry.\(^10\) Part II offers brief background information on the kidney, kidney disease, and medical responses to kidney failure such as hemodialysis and kidney transplantation.\(^11\) It also explains governmental regulation of organ allocation, thereby establishing the government’s role in this form of racial discrimination.\(^12\)

Part III provides empirical evidence pertaining to racial disparities in kidney allocation and offers possible explanations for this inequality.\(^13\) Part IV proposes and analyzes legal and non-legal responses to racial disparities in the allocation of kidneys.\(^14\) This Note concludes that a multifaceted approach inclusive of public education, organ donation publicity campaigns, “presumed consent” laws, alteration of kidney allocation guidelines, creation of placement criteria for kidney allocation, and other measures is necessary to address the issue of racial disparity in the allocation of transplantable kidneys.

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\(^3\) See discussion infra Parts I.A–B and notes 16–57.
\(^4\) See discussion infra Part I.C and notes 58–127.
\(^6\) See discussion infra Part I.A and notes 180–194.
\(^7\) See discussion infra Part I.I.A and notes 180–194.
\(^8\) See discussion infra Part I and notes 16–127.
\(^9\) See discussion infra Parts I.A–B and notes 16–57.
\(^11\) See discussion infra Part II.A and notes 128–165.
\(^12\) See discussion infra Part II.B and notes 166–179.
\(^13\) See discussion infra Part III and notes 180–213.
\(^14\) See discussion infra Part IV and notes 214–297.
allocation waiting lists, and Title VI litigation has the ability to bring about greater racial parity in the allocation of transplantable kidneys.¹⁵

I. HISTORICAL OVERVIEW OF RACIAL DISCRIMINATION IN HEALTH CARE: PRE-CIVIL WAR TO PRESENT DAY

A. Pre-Civil War and Reconstruction

African Americans have long been victims of discrimination in the health care sector of American society.¹⁶ Prior to the Civil War and the abolition of slavery in the United States, almost all African Americans were dependent upon their masters for healthcare.¹⁷ Some slaveholders felt that they had a direct financial interest in the physical well-being of their slaves and thus provided health care to those who worked on their plantations.¹⁸ During the era of slavery, it was not uncommon for plantations to have their own hospitals staffed by African-American women considered knowledgeable on the topics of illness and healing.¹⁹ Other plantation owners formed contracts with local physicians to provide health care for their slaves.²⁰ Despite the availability of health care, however, the quality of treatment that African Americans tended to receive was below the quality of care provided to Americans of European lineage.²¹ For instance, European-American physicians who contracted with plantation owners on a yearly basis tended to provide the minimum amount of care required.²²

¹⁵ See discussion infra Part I.C and notes 58–127.
¹⁷ See SMITH, supra note 16, at 11–12.
¹⁸ Id.
¹⁹ Id.
²⁰ Id.
²² Id. at 811–12.
In addition, during the pre-Civil War period, African Americans were used in various non-consensual medical experiments. European-American doctors often used living African Americans in a wide variety of experimental contexts. During the 1800s, European-American physicians used African Americans to develop gynecological surgical techniques and to determine whether ether was an effective general anesthesia. Thomas Jefferson inoculated 200 of his slaves with the smallpox virus in order to determine the viability of his experimental vaccine. Other known medical experiments conducted on slaves included pouring boiling water on their spinal columns to discover whether this was an effective treatment for typhoid pneumonia, and placing African Americans in an open pit oven to determine if certain medications enabled them to withstand excessive temperatures.

European-American doctors, hospitals and medical schools also relied on the bodies of African Americans for cadaver research and for training medical students. Medical institutions often sent people to steal recently buried bodies from African-American cemeteries in order to maintain a supply of cadavers. Additionally, African-American Siamese twins and other "freaks of nature" were displayed at medical conventions to entertain doctors and give them something at which to gawk.

Following the conclusion of the Civil War and emancipation, African Americans continued to confront overt racism in the health care sector. During Reconstruction, European-American doctors from

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25 See Bernier, supra note 16, at 118–19; Pittman, supra note 21, at 813. For example, Dr. J. Marion Sims, hailed as the founder of modern gynecology, repeatedly performed operations on a group of female slaves in order to develop a surgical procedure to cure vesico-vaginal fistula. See id. Some historical accounts indicate that Dr. Sims failed to provide the African-American women he experimented on with anesthesia, despite its availability. See id. Other accounts explain that Dr. Sims administered opium post-operatively to sedate and pacify the victims of his experiments. See Randall, Trusting the Health Care System, supra note 16, at 197. As a consequence, the women used in these experiments became addicted to narcotics. See id.
26 Randall, Trusting the Health Care System, supra note 16, at 196.
27 Id.
28 Id. at 196–97.
29 Pittman, supra note 21, at 812.
30 Id.
31 Randall, Trusting the Health Care System, supra note 16, at 196.
32 Pittman, supra note 21, at 814–15.
both the North and the South discriminated against African Americans. In response, the Freedmen’s Bureau medical department established ninety hospitals for African Americans throughout the South. Unfortunately, these hospitals were short lived. By 1868, only one of these health care facilities remained in operation.

**B. Jim Crow Era**

During the decades of segregation, overt racism continued to prevail in America’s health care system. In 1896, the Supreme Court delivered the now overruled *Plessy v. Ferguson* decision, holding that the segregation of African Americans and European Americans was not a violation of the Fourteenth Amendment’s Equal Protection Clause of the United States Constitution. Similar to other segments of society, the health care establishment embraced the *Plessy* decision and the Jim Crow legislation that followed on the heels of the opinion. As a consequence of the initial triumph of the separate but equal doctrine, African Americans were excluded from medical schools. This severely limited the number of African-American doctors. Those African Americans who were already doctors were not permitted to practice medicine in hospitals run by European Americans. Southern hospitals excluded African Americans from their premises completely, while hospitals in the North tended to operate separate wards for African American and European American patients. In response, African Americans worked to establish their own hospitals, medical schools and health care facilities.

During the Jim Crow era, African Americans continued to be unknowingly used in medical experiments as well. The most famous illustration of experimentation on African Americans during this era

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36 See id.
37 See id.
38 Id.
39 Id., at 14–21.
is the Tuskegee Syphilis Study. Beginning in July 1932, the United States Public Health Services enrolled approximately 400 African American men with syphilis and 200 African American men without syphilis in an experiment designed to determine the impact of untreated syphilis on the male body. These African Americans, most of whom were poor and uneducated, were not made aware that they had contracted syphilis. Rather, those who were part of the experiment were told that they had “bad blood.” In order to ensure that these men would remain part of the study, they were given burial insurance, hot meals and transportation to and from the hospital. Even after the medical establishment became aware that penicillin was an effective treatment for syphilis, antibiotics were still withheld from the subjects of this experiment. It was not until 1972, forty years after this experiment commenced, that the survivors of the Tuskegee Syphilis Study were informed that they had syphilis and had been the subjects of the longest medical experiment in withholding treatment from humans in recorded history.

Explicit segregation in the realm of health care remained completely intact until the mid-1960s. In 1964, Congress passed the Civil Rights Act, which prohibited federally funded programs and institutions from discriminating on the basis of race. The following year, Congress created the Medicare Program, which made almost all hospitals the recipients of federal funding. As a consequence of their participation in the Medicare Program, almost every hospital in the United States was forced to abide by the provisions of the Civil Rights Act of 1964. Despite attempts to prevent racial integration, medical facilities eventually came to treat patients and hire doctors of all races.

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46 Bernier, supra note 16, at 122–23; Pittman, supra note 21, at 816.
48 Id. at 123.
49 Pittman, supra note 21, at 816.
50 Bernier, supra note 16, at 123.
51 Id.
52 SMITH, supra note 16, at 25.
54 Id.
55 Id.
56 Id.
57 See id.
C. Modern Day Racial Inequalities in Health Care

Despite the gains that have been made since the passage of the Civil Rights Act of 1964, the health care industry remains plagued by racial discrimination.\(^{58}\) It should be noted that, while telling, the information that follows does not illustrate the complete extent to which African Americans are currently discriminated against by the American health care institution.\(^{59}\) Due to the inadequate mechanisms for racial data collection within the health care industry, specifically a failure to report and distribute health care statistics by race, a lack of coordination between agencies responsible for maintaining health care data, and inconsistent definitions of race, it is impossible to fully realize the extent of racial discrimination within the medical sector.\(^{60}\)

1. African-American Health Status

Statistical data indicates that African-American babies have lower birth weights and are more likely to die during the first year of life.

\(^{58}\) See generally Council on Ethical and Judicial Affairs, *Black-White Disparities in Health Care*, 263 JAMA 2344 (1990); Barbara A. Noah, *Racist Health Care?*, 48 Fla. L. Rev. 357 (1996) [hereinafter Noah, Racist Health Care?]; Jane Perkins, *Race Discrimination in America’s Health Care System*, 27 Clearinghouse Rev. 371 (1993). The form of racism that currently exists in the health care sector of American society is sometimes described as institutionalized racism. Vernellia R. Randall, *Racist Health Care: Reforming an Unjust Health Care System to Meet the Needs of African Americans*, 3 Health Matrix 127, 144 (1993) [hereinafter Randall, Reforming an Unjust Health Care System]. Racism comes in different forms. \(^{id}\) Within the context of this Note it is important to draw a distinction between individual racism and institutionalized racism. \(^{See id.}\) Individual racism is overt and typically occurs when individuals of one race act against individuals of another race. \(^{Id.}\) In contrast, institutionalized racism is covert and typically occurs when an entire racial community acts against another racial community. \(^{Id.}\) Institutional racism is

more subtle, less identifiable in terms of specific individuals committing the acts. But it is no less destructive of human life. \ldots\) When black babies die each year because of lack of proper food, shelter and medical facilities, and thousands more are destroyed and maimed physically, emotionally, and intellectually because of the conditions of poverty and discrimination in the black community, that is a function of institutional racism.


\(^{59}\) See Perkins, supra note 58, at 377.

\(^{60}\) Id. at 377–79.
than children born to European-American parents.\textsuperscript{61} For example, African-American babies are twice as likely to die during the first year of life as European-American babies, and children born in countries that are significantly less developed than the United States, such as Kuwait, Costa Rica and Singapore, are more likely to live past age one than children born to African Americans in the United States.\textsuperscript{62}

In addition to the dismal data pertaining to differences in infant mortality and low birth weight, African Americans are generally more likely to die prematurely than European Americans.\textsuperscript{63} The life expectancy for African-American males is seven years lower than the life expectancy for European-American males.\textsuperscript{64} Similarly, the life expectancy for African-American females is five years lower than the life expectancy for European-American females.\textsuperscript{65} Skeptics of this statistical measurement are quick to point out that the homicide rate for African Americans is higher than the homicide rate for European Americans.\textsuperscript{66} When statistical data is examined in various cause of death categories, however, it becomes readily apparent that the higher premature death rate for African Americans is not simply a ramification of a higher incidence of homicide within African-American communities.\textsuperscript{67} For example, African-American men have 100\% more deaths due to diabetes, 92.6\% more deaths due to cerebral vascular disorders, 88.4\% more deaths from cirrhosis of the liver and 81.8\% more deaths due to pulmonary infectious diseases than European-American males.\textsuperscript{68} Additionally, African Americans are more likely than European Americans to contract and suffer from certain diseases such as tuberculosis, asthma, heart disease, cervical cancer, acute respiratory disease, appendicitis, hernia, pneumonia, influenza, and hyperten-

\textsuperscript{61} Id. at 372. Low birth weight babies, any infant weighing less than 2500 grams, are more likely to have moderate and severe forms of mental retardation, cerebral palsy, seizure disorders, blindness, hearing loss and behavioral, learning and language disorders. Id. Thus, babies with low birth weights are more likely to be sickly throughout life than babies born with normal birth weights. Id. Studies indicate that African-American babies are 222.81\% more likely to suffer from low birth weight than European-American babies. Randall, Reforming an Unjust Health Care System, supra note 58, at 140.

\textsuperscript{62} Perkins, supra note 58, at 372.

\textsuperscript{63} Id.

\textsuperscript{64} Id.

\textsuperscript{65} Id.

\textsuperscript{66} See id. at 372; Randall, Reforming an Unjust Health Care System, supra note 58, at 142.

\textsuperscript{67} See Randall, Reforming an Unjust Health Care System, supra note 58, at 142.

\textsuperscript{68} Id.
In summary, when statistical information such as birth weight, infant mortality, life expectancy and the likelihood of contracting certain diseases is examined, it becomes readily apparent that the status of African-American health is lower than the status of European-American health.\textsuperscript{70}

2. African-American Access to Treatment

Despite a tremendous need for medical treatment, many African Americans cannot effectively access medical care.\textsuperscript{71} This inaccessibility is due to a variety of factors, including a lack of health insurance, an inadequate number of health care facilities, "patient dumping," difficulty in obtaining prescription drugs and an insufficient number of African-American doctors.\textsuperscript{72}

Portions of the African-American community are unable to access medical treatment because they do not have medical insurance.\textsuperscript{73} United States citizens do not have a right to health care.\textsuperscript{74} An individual's ability to obtain medical care depends on their ability to obtain employment that provides medical insurance, or on their ability to pay for health care directly.\textsuperscript{75} Thus, access to medical care is dependent upon income level and employment in a position that provides insurance.\textsuperscript{76} The United States' African-American population is disproportionately poor.\textsuperscript{77} African Americans do not tend to hold employment positions that provide medical benefits.\textsuperscript{78} Additionally, Medicaid, public medical insurance for the poor, has financial eligibil-

\textsuperscript{69} Perkins, \textit{supra} note 58, at 372.
\textsuperscript{70} See Council on Ethical and Judicial Affairs, \textit{supra} note 58, at 2344–46; Perkins, \textit{supra} note 58, at 372–77.
\textsuperscript{71} Perkins, \textit{supra} note 58, at 373–77.
\textsuperscript{73} \textit{See} Perkins, \textit{supra} note 58, at 373–74.
\textsuperscript{74} \textit{Id.} at 373.
\textsuperscript{75} \textit{Id.}
\textsuperscript{76} \textit{See id.}
\textsuperscript{77} \textit{Id.} at 374. One third of African Americans are below the poverty line. \textit{Id.} In contrast, 10\% of European Americans are below the poverty line. \textit{Id.} Additionally, 30\% of African-American households report no assets and 50\% of African-American families report assets less than $5,000. \textit{Id.}
\textsuperscript{78} Perkins, \textit{supra} note 58, at 374. Twenty-four percent of African Americans are without medical insurance. \textit{Id.} Only 38.1\% of African-American children are covered by employment provided medical insurance. \textit{Id.} Close to 14\% of European Americans are without medical insurance. \textit{Id.}
ity requirements that strictly limit the number of needy individuals who qualify.\textsuperscript{79} Thus, many African Americans are without any form of medical insurance.\textsuperscript{80}

Individuals that do not have the ability to pay for health care, employer-provided medical insurance, or Medicare are less likely to have regular, preventative care from the medical profession.\textsuperscript{81} Statistics indicate that those without medical insurance are much less likely to have yearly physical exams, pap smears, blood pressure checks, and breast exams.\textsuperscript{82} Furthermore, uninsured patients are more likely to utilize hospital emergency rooms as their primary source of health care.\textsuperscript{83}

Moreover, hospitals use facially neutral practices to effectively limit African-American access to their facilities.\textsuperscript{84} For example, private hospitals and physicians frequently exclude or severely limit the number of low-income patients treated.\textsuperscript{85} Since a large percentage of African Americans are poor, their access to medical care at private facilities is limited.\textsuperscript{86} This problem is seriously exacerbated by the fact that public hospitals located in African-American communities are increasingly closing, relocating to areas with a high European-American population, becoming private facilities or limiting the size of their emergency rooms.\textsuperscript{87} Thus, larger numbers of African Americans are forced to rely on a dwindling number of health care resources.\textsuperscript{88}

Hospitals in the United States also have long maintained the practice of transferring patients considered "undesirable" for a variety of reasons to other health care facilities.\textsuperscript{89} This practice has come to

\begin{itemize}
  \item \textsuperscript{79} See id.
  \item \textsuperscript{80} See id. at 373–75.
  \item \textsuperscript{81} Id. at 374.
  \item \textsuperscript{82} Id.
  \item \textsuperscript{83} Perkins, supra note 58, at 374.
  \item \textsuperscript{84} Randall, \textit{Trusting the Health Care System}, supra note 16, at 210–11.
  \item \textsuperscript{86} Id.
  \item \textsuperscript{87} Id. at 248–49; Randall, \textit{Trusting the Health Care System}, supra note 16, at 210–11.
  \item \textsuperscript{88} See Lado, supra note 85, at 243–52; Randall, \textit{Trusting the Health Care System}, supra note 16, at 210–12.
  \item \textsuperscript{89} Randall, \textit{Trusting the Health Care System}, supra note 16, at 211.
\end{itemize}
be known as “patient dumping.”\textsuperscript{90} Private hospitals have historically transferred (dumped) African Americans to public hospitals.\textsuperscript{91}

In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) as part of the Omnibus Reconciliation Act (COBRA).\textsuperscript{92} This legislation, passed with the intention of curbing patient dumping, made the once commonplace practice illegal.\textsuperscript{93} But, despite good intentions on Capitol Hill, EMTALA has not entirely rectified the problem of patient dumping.\textsuperscript{94} A lack of legislative enforcement mechanisms, coupled with loopholes in the Act, work to ensure that the phenomenon of patient dumping remains a barrier for African Americans who attempt to access medical care.\textsuperscript{95}

Scholars devoted to the study of racial discrimination in the medical profession have also drawn attention to the fact that African Americans are less likely to be prescribed medication than European Americans.\textsuperscript{96} For example, in 1994 the New England Journal of Medicine reported that African-American AIDS patients received prescriptions for needed medications less frequently than European-American AIDS patients even after income, insurance status, mode of HIV transmission and place of residence were controlled for.\textsuperscript{97} Another study conducted on racial discrimination in the dissemination of prescription medication found that African-American children were less likely to leave doctor’s appointments with prescriptions than European-American children.\textsuperscript{98}

African Americans also comprise a disproportionately small percentage of practicing doctors in the United States.\textsuperscript{99} Despite the fact that African Americans account for 12\% of the population, only 3\%
of American doctors are African American.\textsuperscript{100} Increasing the number of African-American doctors through improved education and medical school admission policies that take race into account will increase African-American access to health care because African-American doctors tend to specialize in primary care.\textsuperscript{101} Furthermore, African-American doctors generally practice in locations accessible to African-American communities.\textsuperscript{102}

3. Treatment Received

Research also reveals that, on average, African Americans receive less aggressive treatment for various physical ailments even after income adjustments are made to the data.\textsuperscript{103} For instance, studies pertaining to cardiac treatment reveal that African-American men are half as likely to undergo coronary angiography and one third as likely to undergo coronary artery bypass surgery as European-American men.\textsuperscript{104} These astonishing statistics are even more troubling in light of the fact that African-American males are more likely to suffer from heart disease than European-American males.\textsuperscript{105}

Studies also indicate that the intensity of treatment within the realm of internal medicine is influenced by racial considerations.\textsuperscript{106} Even after income differentials are taken into account, research reveals that African-American patients are less likely to be treated aggressively for illnesses and/or conditions such as pneumonia, kidney failure, and glaucoma than European Americans.\textsuperscript{107} The Journal of the American Medical Association also reports that African-American women have fewer cesarean sections than European-American women even when researchers account for the degree of clinical difficulty of

\textsuperscript{100} Id.

\textsuperscript{101} See id.

\textsuperscript{102} Id.

\textsuperscript{103} See Council on Ethical and Judicial Affairs, \textit{supra} note 58, at 2344–46.

\textsuperscript{104} Id. at 2344.

\textsuperscript{105} See id.

\textsuperscript{106} See Perkins, \textit{supra} note 58, at 376.

\textsuperscript{107} Id. African-American individuals suffering from glaucoma are less likely to undergo corrective surgery than European Americans. \textit{Id.} The magnitude of the disparity differs with geographic location. \textit{Id.} In the mid-Atlantic region, African Americans are 29% less likely to undergo surgery for glaucoma than European Americans. \textit{Id.} In the South, African Americans are 50% less likely than European Americans to have an operation to treat their glaucoma. \textit{Id.}
Within the mental health sector of health care, treatment disparities based on race also exist. For example, African Americans are less frequently considered viable patients for psychotherapy, are more likely to be cared for by an inexperienced therapist and are treated for shorter periods of time, and less intensively, than European-American mental health patients.

Research indicates that, after adjusting for income, some procedures are in fact performed with greater frequency on African-American patients than on European Americans suffering from the same ailments. Unfortunately, those procedures are of the type that most people, regardless of race, would hope to avoid undergoing. For example, African Americans are three times more likely than European Americans to have a partial or total amputation of the leg. Similarly, African-American men are twice as likely to have a bilateral orchietomy in attempts to treat prostate cancer than European-American men. The implications of this research indicate that the medical profession may detect certain illnesses in African Americans at more advanced stages. As a consequence, less invasive and less drastic treatment measures are no longer viable.

4. Experimentation/Clinical Research

Even though present day evidence of medical experimentation on non-consenting African Americans is presently unavailable, it is important to recognize that during the latter portion of the twentieth century African Americans continued to be unknowingly used as subjects in medical experiments. In 1963, the United States Public Health Service and the American Cancer Society provided funding for a research project conducted by doctors working at the Jewish Chronic Disease Hospital of Brooklyn, New York. This research ex-

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108 Council on Ethical and Judicial Affairs, supra note 58, at 2345.
109 See Perkins, supra note 58, at 376.
110 Id.
111 Noah, Racist Health Care?, supra note 58, at 359.
112 See id.
113 Id.
114 Id.
115 See id.
116 See Noah, Racist Health Care?, supra note 58, at 359.
117 See Bernier, supra note 16, at 122.
118 Id.
experiment injected live cancer cells into uninformed, non-consenting African-American patients.\textsuperscript{119}

The year 1972 was witness to yet another disturbing incidence of medical experimentation on African Americans.\textsuperscript{120} In this instance, twenty women, most of whom were African-American, were bused from Chicago, Illinois to Philadelphia, Pennsylvania in order to undergo abortions with a new medical device known as the Super Coil.\textsuperscript{121} Despite the prevailing sentiment of the medical community that the Super Coil should not be used to perform abortions, this device was used on these African-American women.\textsuperscript{122} As a consequence, many of the women suffered uncontrollable bleeding which resulted in shock and necessitated complete hysterectomies in order to save their lives.\textsuperscript{123}

Other research pertaining to racism in medical research reveals that in recent years African-American subjects have been entirely excluded from studies undertaken on new drugs.\textsuperscript{124} This exclusion is said to be motivated by a desire to streamline research and eliminate unnecessary variables.\textsuperscript{125} As a consequence of this failure to include representatives from minority populations in clinical trials, the research community has potentially put members of minority populations at risk by placing drugs in the market without understanding how entire segments of the populous will react to them.\textsuperscript{126} In an attempt to ameliorate this situation, the National Institute of Health issued rules in 1990 requiring pharmaceutical trials to be conducted on minorities unless there is a clear and compelling reason for the exclusion of certain racial/ethnic groups.\textsuperscript{127}

\textsuperscript{119} Id.
\textsuperscript{120} Id.
\textsuperscript{121} Id.
\textsuperscript{122} Bernier, \textit{supra} note 16, at 122.
\textsuperscript{123} Id.
\textsuperscript{124} Noah, \textit{Racist Health Care?}, \textit{supra} note 58, at 365–66. The exclusion of certain populations from drug trials has not been limited to racial/ethnic minorities. \textit{Id.} Historically, females have also not been used as subjects in various pharmaceutical research projects. \textit{Id.}
\textsuperscript{125} Id.
\textsuperscript{126} \textit{See} \textit{id}.
\textsuperscript{127} \textit{Id.} at 366.
II. KIDNEY TRANSPLANTATION: BACKGROUND INFORMATION AND EXPLANATION OF FEDERAL REGULATION

A. The Kidney, Kidney Disease and Treatment Options

The kidney is a bean-shaped organ that, on average, weighs 140 grams. Humans have two kidneys located behind the lower abdominal cavity. The human kidneys filter out various substances from an individual’s blood. Each day roughly 180 liters of fluid are passed through the kidneys. Some of what is filtered out is reabsorbed by the kidneys in order to maintain a proper balance of electrolytes and fluids. The majority of substances filtered from the blood are turned into urine by the kidneys. Thus, the kidneys work to ensure that human beings are not poisoned by the accumulation of metabolism’s waste products. Kidney failure has many potential causes including injury, infection, kidney stones, cancer and disorders in other parts of the human body, such as high blood pressure or diabetes. At times kidney failure occurs without any apparent cause. When an individual’s kidneys fail to function properly waste products build up in their body, resulting in sickness or death.

There are two main treatment options for chronic kidney failure: hemodialysis and kidney transplantation. Hemodialysis is a means by which waste products are filtered from the blood by a machine that, in effect, performs the function of the kidneys. On average, patients receiving dialysis treatment for chronic kidney failure must undergo treatment three times a week. Hemodialysis sessions tend...
to last between four to six hours and typically take place at either a hospital or a dialysis center.\footnote{141}{Id.}

Hemodialysis is far from a pleasant experience.\footnote{142}{See Kevin McCoy, Wait for Organs is Long and Painful: Black New Yorkers in Need of Kidneys Suffer Longest, N.Y. DAILY NEWS, Aug. 9, 1999, at 6.} Dialysis patients are often plagued by fatigue; some patients are so tired that they become unable to work or live a normal lifestyle.\footnote{143}{See id.} Additionally, it is not uncommon for individuals undergoing hemodialysis to require surgery to repair the blood vessels used in dialysis treatment.\footnote{144}{Id.} Individuals undergoing dialysis may also be susceptible to infection because of problems with sterility.\footnote{145}{Id. at 98.} However, the problem of sterility has been somewhat mitigated because now most dialysis machines have disposable parts.\footnote{146}{Id.}

The second treatment option available to individuals suffering from chronic renal failure is kidney transplantation.\footnote{147}{Id.} Although the notion of organ transplantation is ancient, the first successful kidney transplantation was not performed until 1954.\footnote{148}{Id. at 98.} The kidney is a relatively easy organ to transplant because it does not need to be connected with the central nervous system in order to function properly.\footnote{149}{Id.} When transplanting a kidney, the surgeon only needs to connect the organ to a major artery, a major vein and the ureter, a tube-like structure that connects the kidney to the bladder.\footnote{150}{Id.}

Life on dialysis is, to put it mildly, onerous. To exist is possible, to thrive unusual, and to prosper almost unheard of. The dialysis patient must keep on a strict diet. . . . The dialysis patient is subjected to a daily, never-ending procession of needles, tubes, blood work, and injections. . . . Marcia Campbell Marden has described life on dialysis: “A year ago I would not let you see me without mascara. Today you can view me three times a week without my pride. . . . I am dry, and always, always thirsty. . . . I smell old and sick. And even Shalimar cannot cover the odor of dialysate. . . . I am afraid. . . . I am determined to escape this.”


\footnote{145}{See The World Book Medical Encyclopedia, supra note 129, at 512.} \footnote{146}{Id.} \footnote{147}{Mintz & Eichenlaub, supra note 128, at 98–102.} \footnote{148}{Id. at 98.} \footnote{149}{Id.} \footnote{150}{Id.}
With surgical technique near perfection in the area of renal transplantation, one of the stumbling blocks to kidney transplantation is rejection by the immune system. In order to prevent the recipient's immune system from attacking the transplanted organ, drugs which suppress the immune system are administered to the recipient. A side effect of these medications is a weakened immune system, which creates an inability to fight disease.

Another major obstacle in the area of kidney transplantation is the lack of available organs. Transplantable kidneys may be obtained from either living or cadaver donors. Since human beings have two kidneys and are able to live a normal life with only one, the medical establishment permits living relatives to donate one of their kidneys to a family member. Kidneys can also be obtained from deceased individuals who indicate that they are willing to donate their organs upon their death.

Despite efforts to increase organ donation, the public response has been dismal. Many refuse to donate their organs upon death because they fear doctors will hasten their death when it becomes known that they are an organ donor, because they are unwilling to face their own mortality or because they have religious convictions that require that the body of a deceased person be kept intact. The failure of individuals to donate their organs, while significant, is not the only reason why the United States faces a shortage of transplantable organs. Often, the organs of individuals who have indicated that they wish to be an organ donor upon their death are not harvested. Before doctors harvest the organs of an individual who indicated a desire to donate while still alive, consent is almost always sought from surviving family members. It is not uncommon for

151 Id.
152 Mintz & Eichenlaub, supra note 128, 98–99.
153 Id. at 99.
154 Id. at 100.
155 Id.
156 Id.
157 See Mintz & Eichenlaub, supra note 128, at 100–01.
158 See CURRAN ET AL., supra note 92, at 720–21.
159 Id. at 721.
160 See id.
161 Id.
162 Id. The Uniform Anatomical Gift Act, a form of which is operative in almost all states, does not require the consent of anyone other than the individual who will make the donation upon their death. UNIF. ANATOMICAL GIFT ACT § 2(e) (1987). Despite this, al-
family members to withhold consent, or for physicians to neglect to ask for permission to harvest the organs of a deceased individual.163 Typically, patients suffering from chronic renal failure prefer kidney transplantation to dialysis.164 Studies indicate that individuals that have undergone successful renal transplants enjoy a higher quality and longer life than patients maintained on dialysis.165

B. Regulation of Organ Allocation

The allocation of organs is governed by the National Organ Transplant Act of 1984.166 This federal legislation created the Organ Procurement and Transportation Network (OPTN), a private, non-profit organization, to develop standards for the allocation of transplantable organs and to create a system to match individuals donating organs with medical patients in need of a replacement organ.167 Since 1986, the Federal Department of Health and Human Services has awarded the contracts to operate OPTN to the United Network for Organ Sharing (UNOS).168 UNOS is an organization comprised of organ procurement agencies, transplant surgery centers, medical laboratories, volunteers and advocacy groups, organ donors and their families, organ recipients and their families, and patients awaiting an organ for transplantation.169

The individual organ procurement agencies, one sector of UNOS’ membership, are charged with the duty of obtaining organs from the geographical area where they are located.170 Organ procurement agencies also allocate organs to individuals in need of an organ who reside in the same geographical location as the organ procurement agency.171 If no one residing in the same geographic area is in need of the procured organ, then the organ may be given to another organ procurement agency.172 As a result of the fact that UNOS

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163 Curran et al., supra note 92, at 721.
164 Dooley & Gaston, supra note 144, at 718.
165 See id.
167 Id. § 274(b); Curran et al., supra note 92, at 721–22.
168 Curran et al., supra note 92, at 767.
169 Id.
170 Id.
171 Id.
172 See id.
maintains several waiting lists based on geographical location, an individual’s place of residence can potentially impact their ability to obtain a much needed organ for transplantation.\textsuperscript{173}

As a whole, UNOS issues allocation guidelines which the individual organ procurement agencies abide by when allocating organs to individuals on UNOS’ waiting lists.\textsuperscript{174} Generally speaking, UNOS allocation guidelines give consideration to the amount of time an individual has spent on an UNOS waiting list, medical urgency and possibility for successful transplantation.\textsuperscript{175} Specific UNOS allocation guidelines for kidneys do not place a significant amount of emphasis on medical urgency because most patients seeking a kidney for transplantation can be maintained on dialysis.\textsuperscript{176} Rather, emphasis is placed on the length of time the kidney recipient will benefit from the transplant and the compatibility of the donor and the recipient.\textsuperscript{177} At this time, UNOS has not issued guidelines to help organ procurement agencies determine who should be placed on UNOS waiting lists.\textsuperscript{178} Thus, local organ procurement agencies have been free to develop their own policies concerning which individuals should be placed on organ allocation waiting lists.\textsuperscript{179}

III. EMPIRICAL EVIDENCE PERTAINING TO RACIAL DISCRIMINATION IN KIDNEY TRANSPLANTATION

A. African-American Access to Transplantable Kidneys: Increased Need and Decreased Likelihood of Receipt

Studies indicate that African Americans are more likely than European Americans to have chronic renal failure, and thus more likely to be in need of a kidney transplant.\textsuperscript{180} Data reveals that even though African Americans comprise only 12% of the population of the United States, they comprise 34% of the people suffering from

\textsuperscript{173} CURRAN ET AL., supra note 92, at 767, 774–75. Waiting list times vary considerably with geographic location. \textit{Id.}
\textsuperscript{174} \textit{Id.} at 767.
\textsuperscript{175} \textit{Id.}
\textsuperscript{176} \textit{Id.} at 773.
\textsuperscript{177} \textit{Id.}
\textsuperscript{178} CURRAN ET AL., supra note 92, at 767.
\textsuperscript{179} See \textit{id.}
\textsuperscript{180} \textit{Id.} at 782.
chronic renal failure in the United States. Experts think that the African-American population’s high rate of renal failure is due to a form of high blood pressure known as low-renin hypertension. Scientists suspect that low-renin hypertension is more prevalent among African Americans because the kidneys of African Americans evolved under the pressure of limited access to salt. In response to inadequate amounts of salt, experts believe that African Americans developed cellular mechanisms that permitted them to increase their salt retention. In contrast, African-American salt intake in the modern era is high. Consequently, excess salt in the diets of African Americans coupled with a genetic propensity to retain salt has increased the likelihood that African Americans will suffer from low-renin hypertension and thus chronic renal failure. Additionally, due to a lack of access to adequate health care, African Americans are less likely than European Americans to be diagnosed with high blood pressure or to receive treatment for high blood pressure prior to developing serious renal damage.

Despite having greater need for replacement kidneys than European Americans, African Americans are less likely to receive a kidney transplant than Europeans Americans or other minorities. A study reported in the Journal of the American Medical Association revealed that patients treated at medical facilities which primarily serve European-American communities and are located in high income areas are more than twice as likely to be the recipient of a kidney donation as are patients treated by hospitals that typically serve African-American patients and are located in low income areas. Discrepancies based on race continue to exist after controlling for variables such as the cause of kidney failure, age and income. Even though

181 Noah, Racial Disparities, supra note 96, at 143.
182 Dooley & Gaston, supra note 144, at 714.
183 Id. “Some have suggested that passage to America in slave ships, with limited supplies of salt and water, might have exerted even more genetic pressure by favoring survival of those Africans best able to retain salt.” Id.
184 Id.
185 Id.
186 See id.
187 See discussion supra Part I.
188 Dooley & Gaston, supra note 144, at 714.
189 Id. at 715.
190 Council on Ethical and Judicial Affairs, supra note 58, at 2345.
191 CURRAN ET AL., supra note 92, at 782.
European Americans account for only 61% of the nation’s dialysis population, they receive 74% of all kidney transplants. In contrast, African Americans account for 33% of the nation’s dialysis population and receive only 22% of the kidneys available for transplantation. Studies show that, on average, European Americans have a 78% higher chance of obtaining a kidney transplant than African Americans, and that African Americans spend twice as much time on organ donation waiting lists as European Americans.

B. Why African Americans Receive Fewer Kidneys

Various possible explanations have been offered to explain why, despite a more acute need for kidneys, African Americans are less likely than European Americans to be recipients of kidney donations. First, attention has been given to the fact that African Americans are less likely to donate kidneys than European Americans. Data indicates that, during 1998, African Americans donated only 12% of all living transplants and only 8% of cadaveric kidneys. Based on a long, tortuous history of mistreatment and discrimination by the medical sector, African Americans tend to distrust the health care establishment, resulting in a decreased desire to make living kidney donations because they fear not receiving adequate medical treatment during the donation period. Also, some African Americans are less likely to gift their organs upon death because they suspect that once they agree to become organ donors their lives will be valued less.

193 Id. at 220.
194 Dooley & Gaston, supra note 144, at 715; Randall, Trusting the Health Care System, supra note 16, at 220.
195 King & Wolf, supra note 53, at 1029.
196 Randall, Trusting the Health Care System, supra note 16, at 220; see Susan Okie, Racial Disparity Seen in Kidney Transplants, Blacks Less Likely to Be Recipients, Donors, WASH. POST, Jan. 31, 1991. “Blacks are only half as likely as whites to receive a kidney from a relative. Twenty-five percent of kidneys received by white patients come from a living relative, compared with about 12% of kidneys received by black patients.” Id.
197 King & Wolf, supra note 53, at 1029.
198 Id.; see also Randall, Trusting the Health Care System, supra note 16, at 220–21. Community rumors contribute to the fear of African Americans regarding organ donation King & Wolf, supra note 53, at 1029; see also Randall, Trusting the Health Care System, supra note 16, at 220–21. Rumors circulate in African-American communities about African Americans being prematurely declared brain dead so that their organs may be harvested for the benefit of European Americans in need of transplantation. King & Wolf, supra note 53, at 1029; see also Randall, Trusting the Health Care System, supra note 16, at 220–21.
Second, the possibility exists that doctors are less likely to place African-American patients on UNOS waiting lists than European-American patients.\textsuperscript{199} Before a patient can be placed on an UNOS waiting list, a doctor must evaluate the patient and determine whether the individual should be referred to an organ procurement agency, which will then decide whether to put the patient on the waiting list.\textsuperscript{200} Historically, UNOS has not issued guidelines to help physicians determine who should be referred to procurement agencies for placement on waiting lists.\textsuperscript{201} The possibility exists that doctors make racial value judgments at this juncture.\textsuperscript{202} The potential for racially-biased decision making exists at this stage, as much as at the organ allocation stage of the transplant process.\textsuperscript{203}

Third, until recently, UNOS guidelines for the allocation of kidneys required a close antigen match between the donor and the recipient.\textsuperscript{204} As mentioned above, the guidelines issued by UNOS for the allocation of kidneys do not place much emphasis on medical urgency because individuals with chronic renal failure can be maintained on dialysis.\textsuperscript{205} Rather, kidney allocation guidelines have traditionally focused on human leukocyte antigen (HLA) matching.\textsuperscript{206} Thus, individuals on UNOS kidney waiting lists that exhibit a close HLA match to the donated organ are more likely to be chosen as the transplant recipient.\textsuperscript{207} Since the HLA match percentage between African Americans and European Americans is low, African Americans, who, as a population, are in the greatest need of kidneys, do not benefit from the emphasis UNOS places on close HLA matching.\textsuperscript{208}

The National Organ Transplant Act of 1984 directed the Organ Procurement and Transportation Network, whose contract has been continuously awarded to UNOS, to allocate all organs “equitably

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\item[199] See Noah, \textit{Racial Disparities}, supra note 96, at 143–44.
\item[200] Dooley & Gaston, \textit{supra} note 144, at 715.
\item[201] See \textit{CURRAN ET AL.}, \textit{supra} note 92, at 767.
\item[202] Noah, \textit{Racial Disparities}, supra note 96, at 143–44; see Kevin McCoy, \textit{Deadly Disparity in Transplants: Blacks and Hispanics Deprived}, \textit{N.Y. Daily News}, Aug. 8, 1999, at 6. “The main factor blocking blacks and Hispanics from transplants was that they weren’t placed on organ waiting lists. This happened largely because their doctors did not refer them to transplant centers. . . . They don’t make it nearly as often as whites.” \textit{Id.}
\item[203] Noah, \textit{Racial Disparities}, supra note 96, at 143–44.
\item[204] \textit{Id.} at 145.
\item[205] \textit{CURRAN ET AL.}, supra note 92, at 773.
\item[206] Noah, \textit{Racial Disparities}, supra note 96, at 145.
\item[207] \textit{See id.}
\item[208] \textit{Id.}
\end{footnotes}
among transplant patients” and “in accordance with established medical criteria.” Based on this explicit legislative directive, it is clear that Congress intended for equitable and practical outcome considerations to influence the allocation of organs. The emphasis placed on close antigen matching in the area of kidney distribution leads to the inescapable conclusion that UNOS has placed emphasis on an effective outcome at the expense of an equality-based outcome. The small gains that close tissue matching contributes to the overall success of kidney transplantation are not a sufficient justification for disadvantaging African Americans in need of kidney transplants. In addition, it is important to point out that new anti-rejection drugs, such as cyclosporine, have the potential to make close HLA matching medically unnecessary. The next portion of this Note will explore possible responses to the lack of racial parity in the allocation of transplantable kidneys.

IV. LEGAL RESPONSES TO RACIAL DISPARITIES IN THE ALLOCATION OF KIDNEYS

A. Increase African-American Donation: Education, Publicity Campaigns, Establishment of Greater Trust in the Health Care System and “Presumed Consent” Laws

In order to increase the percentage of African Americans making either cadaver or living kidney donations, a multifaceted approach must be pursued. Via educationally oriented publicity campaigns, African-American communities should be made aware that members

209 42 U.S.C. § 274(b) (2) (A), (D) (1994).
210 See id.
211 See id.; Noah, Racist Health Care?, supra note 58, at 364.
212 Noah, Racist Health Care?, supra note 58, at 364.
213 Noah, Racial Disparities, supra note 96, at 145.
214 A problem as large and complex as the one presented should be attacked from various angles. Lado, supra note 85, at 256. Legal responses are one avenue that can and should be pursued in order to bring about racial parity in the allocation of kidneys. See id. However, the law, working in isolation, will not be able to effectively ameliorate this situation. See id. Other means of attacking racial inequity in the area of kidney allocation must be pursued. See id. Within the scientific realm researchers must continue to explore and develop alternative organ procurement options, such as xenotransplantation (animal to human transplantation), cloning (inducing animals to grow organs that have antigens that are compatible with humans) and new immune suppressing drugs. See Dooley & Gaston, supra note 144, at 723–24.
215 See Lado, supra note 85, at 256.
of their race suffer a higher incidence of kidney failure than other racial groups in the United States and that, as a group, African Americans donate fewer organs than other racial sectors of American society. In addition to informing and educating African Americans about the shortage of transplantable kidneys and thus, the need for increased donation, efforts must be undertaken to foster African-American trust in the United States health care system. The goal of instilling African-American trust in the medical establishment can be pursued by acknowledging past wrongs. Working to eliminate present inequalities by bringing lawsuits that challenge discriminatory practices will also work to create African-American trust. Increasing the number of African-American doctors and nurses has the potential to ameliorate the problem of African-American distrust in the health care industry as well.

Suggestions have also been made that the general problem of an inadequate supply of transplantable organs can be rectified by passing legislation that mandates "presumed consent" to organ donation. These proposed statutes would presume that all mentally competent Americans over the age of eighteen consent to the collection of transplantable organs upon their death. Proposals for presumed consent legislation typically contain opt-out provisions so that individual autonomy and self-determination, two strong tenets of American government, are not destroyed. Advocates of presumed consent statutes draw attention to the fact that several nations, such as Austria, Belgium, Israel and New Zealand, have enacted presumed consent laws. Finally, advocates point out that twenty US states have presumed consent laws for cornea and pituitary gland donation.

216 See id.
217 See SMITH, supra note 16, at 26; Lado, supra note 85, at 256.
218 See Randall, Trusting the Health Care System, supra note 16, at 233–34.
219 See Perkins, supra note 58, at 379.
220 See SEMMES, supra note 72, at 112–13.
222 Fentiman, supra note 221, at 1598.
223 Id.
224 Id. at 1599.
225 Id.
B. Development of UNOS Waiting List Criteria

As discussed in Part III, physicians may be less likely to place African Americans on UNOS kidney allocation waiting lists than European Americans. This is potentially a significant obstacle to African Americans in need of a kidney transplantation because placement on an UNOS waiting list is an essential first step in order to receive consideration for a kidney donation. In order to help eliminate racial discrimination at this juncture, UNOS is in the process of developing standard criteria for determining when an individual should be placed on kidney allocation waiting lists. As we have seen in regards to the guidelines that UNOS has prescribed for the actual allocation of kidneys to patients already on organ waiting lists, however, the criteria themselves might actually contribute to disparities based on race and therefore fail to improve this dismal situation. Thus, while the creation of UNOS guidelines pertaining to the placement of patients on organ donation waiting lists can generally be perceived as a step towards greater equality in organ allocation, only time will tell whether in practice these guidelines will work to ameliorate racial discrimination.

C. UNOS Kidney Allocation Guidelines

In 1995, UNOS responded to concerns pertaining to racial disparities in kidney allocation by modifying kidney allocation guidelines. The amended UNOS guidelines still take antigen matching into consideration when making allocation determinations. Now, however, UNOS places less emphasis on partial antigen matches than it previously did, and gives greater consideration to time spent on the waiting list. As a result of these alterations in the UNOS kidney allocation guidelines, a larger percentage of kidneys are being donated to African-Americans without the anticipated decline in kidney transplant

226 See Dooley & Gaston, supra note 144, at 715–16.
227 See id.
228 CURRAN ET AL., supra note 92, at 772.
229 See id. at 772–73; Dooley & Gaston, supra note 144, at 715–16; Noah, Racial Disparities, supra note 96, at 145–46.
230 See CURRAN ET AL., supra note 92, at 772–73; Dooley & Gaston, supra note 144, at 715–16; Noah, Racial Disparities, supra note 96, at 145–46.
231 CURRAN ET AL., supra note 92, at 783.
232 Dooley & Gaston, supra note 144, at 720.
233 Id.
survival rate. In fact, since the kidney allocation changes were made in 1995, the survival rate for kidney transplant patients has actually improved.

While these changes should be applauded, it is important to recognize that more drastic alterations need to be made before racial parity in the area of kidney allocation will exist. Based on the relative success of the 1995 changes to the UNOS kidney allocation guidelines, attention should be given to the possibility of placing even less emphasis on antigen matching.

D. Litigation

1. Potential Claims Under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution

The suggestion has been made that a claim against UNOS could be brought under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. While this means of pursuing greater racial equality in kidney allocation is within the realm of possibility, obstacles stand in the way of the potential success of an Equal Protection claim against UNOS. For an Equal Protection challenge to be effective, the plaintiff has to overcome two major hurdles: state action and intent to discriminate.

To determine whether or not state action is present in the Equal Protection context, the Supreme Court considers whether the defendant is engaged in a public function, or whether a sufficiently close nexus exists between the defendant and the government or, finally, whether the government compels the harm caused by the defendant. One scholar has made the argument that UNOS qualifies as a state actor, under the government compulsion test, due to the gov-

234 See Curran et al., supra note 92, at 783; Dooley & Gaston, supra note 144, at 720.
235 Dooley & Gaston, supra note 144, at 720.
236 See id.
237 See id.; Noah, Racial Disparities, supra note 96, at 145–46.
239 See id. at 367–76 (discussing whether UNOS is a state actor).
240 Id. at 367–76, 384.
241 Id. at 358–59.
ernment's involvement in the making of UNOS rules and guidelines. 242

The plaintiff would also need to show that UNOS intended to discriminate against African Americans. 243 In Washington v. Davis, the Supreme Court made clear that there must be intentional, purposeful discrimination in order to state a claim under the Equal Protection Clause; discriminatory impact alone is not enough to establish a prima facie Fourteenth Amendment Equal Protection claim. 244 Since there is seemingly no evidence of purposeful discrimination on the part of UNOS, this is a significant obstacle. 245 An argument has been made, however, that a potential plaintiff bringing a suit against UNOS could claim that, although UNOS kidney allocation guidelines are not facially discriminatory, the emphasis placed on antigen matching is, in effect, the equivalent of an explicit racial classification and thus, the Supreme Court is required to evaluate UNOS kidney allocation guidelines under the rubric of strict scrutiny. 246 Because a potential plaintiff challenging UNOS under the Equal Protection Clause would need to overcome the significant obstacles of state action and intent to discriminate, an Equal Protection claim may not be the best legal option for African-American plaintiffs. 247

2. Potential Claims Under Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 is better suited to the goal of bringing about increased racial equality in the allocation of transplantable kidneys. 248 Title VI of the Civil Rights Act of 1964 requires programs receiving federal funding to treat individuals of different races, colors and national origins equally. 249 It reads: "No person in the United States shall, on the grounds 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 receiv-

242 Id. at 374–76.
243 See Mintz, supra note 238, at 384.
245 See Mintz, supra note 238, at 384.
246 See id. at 386–89.
247 See id. at 367–76, 384.
ing Federal financial assistance.\footnote{Id.} Under Title VI, those seeking federal funding have a choice to make: they can either accept federal financial assistance and consequently accept the conditions attached to the receipt of those funds, equal treatment of all races, or they can forego federal funding and be free of the legal obligation to treat races equally.\footnote{Id.; Jurevic, supra note 248, at 240.} As a consequence of Medicare/Medicaid legislation, almost all hospitals in operation in the United States receive federal funding and thus have a Title VI obligation not to discriminate on the basis of race, color or national origin.\footnote{See Perkins, supra note 58, at 379.} Because Title VI is vague, administrative regulations have been required for interpretation and enforcement of this statute.\footnote{Daniel K. Hampton, Title VI Challenges by Private Parties to the Location of Health Care Facilities: Toward a Just and Effective Action, 37 B.C. L. Rev. 517, 520–21 (1996).}

Title VI has two possible enforcement mechanisms.\footnote{Jurevic, supra note 248, at 241.} First, Title VI provides for administrative enforcement via the Department of Health and Human Services' (HHS) Office of Civil Rights (OCR).\footnote{Sidney D. Watson, Health Care in the Inner City: Asking the Right Question, 71 N.C. L. Rev. 1647, 1669–70 (1993).} In practice, unfortunately, OCR does not serve as an effective enforcement mechanism for Title VI because OCR has failed to collect the data necessary to determine whether hospitals and other health care facilities are in compliance with Title VI.\footnote{Id.} Without such data, it is difficult for OCR to ascertain the existence of racial discrimination and thus to sanction hospitals in violation of Title VI.\footnote{See id.} In order to bring about greater racial equality in the allocation of organs for transplantation, a suit could be brought against HHS claiming that the agency’s failure to monitor, and consequently sanction, caused injury-in-fact to the plaintiff.\footnote{Ian Ayres et al., Unequal Racial Access to Kidney Transplantation, 46 Vand. L. Rev. 805, 859 (1993).} In order to present a justiciable claim against HHS, the plaintiff would also need to demonstrate that a judicial remedy is available.\footnote{Id. at 859 n.248.}
Title VI also allows private parties to file legal complaints alleging a Title VI violation. In response to racial discrimination in the health care sector, Title VI has been used by private plaintiffs in attempts to prevent hospitals geographically situated in predominately African-American communities from closing or relocating to European-American neighborhoods. The Supreme Court has determined that Title VI applies when there is disproportionate adverse impact discrimination, without proof of intent to discriminate, so long as the plaintiff alleges a violation of Title VI's implementing regulations.

In Alexander v. Choate, the Supreme Court clarified what amounted to a confusing set of prior opinions on the issue of whether Title VI required purposeful discrimination. Here, the Court first held that Title VI, on its own, apart from its implementing regulations, applies only to intentional discrimination. The Court went on to state, however, that Title VI plaintiffs can state a claim by showing disproportionate adverse impact, without proof of intent to discriminate, as long as the plaintiff takes care to allege a violation of Title VI implementing regulations.

The prima facie case for a Title VI claim involves three elements. First, there must be state action proved via federal financial assistance. Second, there must be an agency regulation that prohibits actions that have the effect of treating people of different races, colors or national origins differently. Third, there must be a disproportionate effect on a particular race.

If the plaintiff can successfully allege a prima facie case, the burden shifts to the defendant. Once the burden shifts, the defendant

261 See Hampton, supra note 253, at 536–49; Sidney D. Watson, Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn’t Be So Easy, 58 Fordham L. Rev. 939, 966–71 (1990) [hereinafter Watson, Title VI].
262 Alexander v. Choate, 469 U.S. 287, 293 (1985); Watson, Title VI, supra note 261, at 952–53.
263 Choate, 469 U.S. at 293; see Guardians Ass’n v. Civil Serv. Comm’n, 463 U.S. 582, 584 (1983).
264 Choate, 469 U.S. at 293.
265 Id. at 293–94.
266 Jurevic, supra note 248, at 241.
267 Id.
268 Id.
269 Id.
270 Id.
must offer evidence to justify the unequal effect. Courts have been unclear as to whether, at this juncture in litigation, the burden shifts back to the plaintiff. Experts have suggested that Title VII case law should be used as a guide. Hence, under the Title VII model as applied to a Title VI lawsuit, if the defendant is able to present a valid justification, the burden should shift back to the plaintiff. At this stage, the plaintiff would need to demonstrate that a less discriminatory alternative exists. Title VI claims have the potential to serve as a useful weapon in the battle against racial inequality in the allocation of transplantable organs. Within the area of racial discrimination in the distribution of organs for transplantation, it is conceivable that Title VI lawsuits could be brought against UNOS itself for failure to equitably allocate organs for transplantation and against individual hospitals for failure to place African-American patients on UNOS organ allocation waiting lists.

It is likely that an African-American plaintiff in a case brought against UNOS for failure to equitably distribute organs would be able to satisfy the prima facie elements of a Title VI claim. First, the federal financial assistance requirement is likely to be satisfied. UNOS operates under a government contract. More importantly, UNOS is the recipient of federal funding. Based on these factors, a court is likely to hold that UNOS is a state actor. Second, the plaintiff would need to point to the Title VI implementing regulations that forbid organizations receiving federal funding (in this instance UNOS) from using "criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect

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271 Jurevic, supra note 248, at 241.
272 See Watson, Title VI, supra note 261, at 954.
273 Id. at 955.
274 See id. at 958.
275 See supra id.
276 See Ayres et al., supra note 258, at 853–60.
277 Id. at 859; see Hampton, supra note 253, at 542–49.
278 See Ayres et al., supra note 258, at 855–59.
279 See id. at 859.
280 CURRAN ET AL., supra note 92, at 767.
281 Ayres et al., supra note 258, at 859.
282 See CURRAN ET AL., supra note 92, at 767; Ayres et al., supra note 258, at 859.
individuals of a particular race, color, or national origin."\textsuperscript{283} Third, the African-American plaintiff would need to establish that the UNOS guidelines for the allocation of kidneys have a discriminatory impact on African-Americans.\textsuperscript{284} The African-American plaintiff should focus on the fact that UNOS kidney allocation guidelines still place emphasis on antigen matching.\textsuperscript{285} Thus, European Americans receive a greater percentage of the kidneys available for transplantation.\textsuperscript{286} After the establishment of a prima facie case, the burden would shift to UNOS.\textsuperscript{287} In order to provide justification for the disparate impact on African Americans, UNOS would most likely try to persuade the court that antigen matching is essential for effective kidney transplantation.\textsuperscript{288}

Finally, if UNOS is successful in arguing the validity of antigen matching, the burden may shift back to the plaintiff.\textsuperscript{289} At this point the plaintiff would need to convince the court of the existence of equally effective, non-discriminatory alternatives to the current UNOS kidney allocation guidelines.\textsuperscript{290} Here, the plaintiff should argue that an organ allocation system which places even less emphasis on partial antigen matching and awards equitable points for the presence of uncommon antigens will promote greater racial equality without sacrificing overall effectiveness.\textsuperscript{291} During this final phase of litigation, the plaintiff should remind the court that Congress mandated that the allocation of organs be both efficient and equitable.\textsuperscript{292} The less discriminatory alternative proposed by the plaintiff, an organ allocation system that places little emphasis of partial antigen matches, has the potential to realize both the efficiency and the equitable legislative mandates.\textsuperscript{293}

An African-American plaintiff may also be able to state a Title VI claim against a hospital that fails to place African Americans on

\textsuperscript{283} 45 C.F.R. \S 80.3(b)(2) (1973).
\textsuperscript{284} See Jurevic, supra note 248, at 241.
\textsuperscript{285} Ayers et al., supra note 258, at 855–56.
\textsuperscript{286} \textit{Id}.
\textsuperscript{287} Jurevic, supra note 248, at 241.
\textsuperscript{288} Ayers et al., supra note 258, at 856–57.
\textsuperscript{289} See Watson, \textit{Title VI}, supra note 261, at 955, 958.
\textsuperscript{290} See Ayers et al., supra note 258, at 855–57.
\textsuperscript{291} \textit{Id} at 856–57.
\textsuperscript{292} See 42 U.S.C. \S 274(b)(2)(A), (D) (1994).
\textsuperscript{293} See Ayers et al., supra note 258, at 858.
UNOS kidney allocation waiting lists.\textsuperscript{294} In such a case, the court would most likely find federal financial assistance because most hospitals are the recipients of federal funding.\textsuperscript{295} Second, the plaintiff should draw attention to the Title VI implementing regulations that forbid organizations receiving federal funding, in this instance the individual hospital, from using "criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin."\textsuperscript{296} Finally, the plaintiff would need to present evidence to prove that the hospital is in fact discriminating against African Americans by failing to place African Americans on UNOS kidney allocation waiting lists.\textsuperscript{297}

**CONCLUSION**

At the dawn of the twenty-first century, racism continues to infect health care in the United States.\textsuperscript{298} Although blatant forms of racial discrimination have been eradicated, more subtle variations continue to make access to and delivery of health care dependent upon race.\textsuperscript{299} Racial inequality is readily apparent in the allocation of transplantable kidneys.\textsuperscript{300} Despite having higher rates of kidney failure than European Americans, African Americans are less likely to be the recipients of transplantable kidneys and spend considerably longer periods of time on kidney allocation waiting lists than European Americans.\textsuperscript{301}

In order to ameliorate racial inequality within the sphere of kidney allocation a battle must be waged from various fronts.\textsuperscript{302} With education, organ donation publicity campaigns and possibly the enactment of presumed consent statutes, the supply of transplantable organs has the potential to increase.\textsuperscript{303} The creation of UNOS organ allocation waiting list criteria and the 1995 alterations to UNOS allo-

\textsuperscript{294} See Hampton, supra note 253, at 543–49 (explaining recent cases brought against hospitals under Title VI); Jurevic, supra note 248, at 241.
\textsuperscript{295} See Perkins, supra note 58, at 379.
\textsuperscript{296} 45 C.F.R. § 80.3(b)(2) (1973); Jurevic, supra note 248, at 241.
\textsuperscript{297} See Jurevic, supra note 248, at 241.
\textsuperscript{298} See discussion supra Part I.C and notes 50–119.
\textsuperscript{299} See discussion supra Parts I.B–C and notes 29–119.
\textsuperscript{300} See discussion supra Part III.A and notes 172–186.
\textsuperscript{301} See discussion supra Part III.A and notes 172–186.
\textsuperscript{302} See Lado, supra note 85, at 256.
\textsuperscript{303} See discussion supra Part IV.A and notes 207–217.
cation guidelines have the potential to bring about increased racial equality.\textsuperscript{304}

If, however, racial parity remains an unachieved goal, UNOS must be forced to further revise waiting list criteria and allocation guidelines.\textsuperscript{305} It may also be possible to bring an Equal Protection suit against UNOS.\textsuperscript{306} Additionally, Title VI claims, filed against either UNOS or individual hospitals, have the potential to help eliminate racial disparity.\textsuperscript{307} Working in concert, these varied responses have the ability to bring about greater racial equality in the sphere of kidney allocation.\textsuperscript{308}

\textsuperscript{304} See discussion supra Parts IV.B–C and notes 218–29.
\textsuperscript{305} See discussion supra Parts IV.B–C and notes 218–229.
\textsuperscript{306} See discussion supra Part IV.D and notes 230–240.
\textsuperscript{307} See discussion supra Part IV.D and notes 241–289.
\textsuperscript{308} See discussion supra Part IV and notes 207–289.