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**Before the Assembly Standing Committee on Health
Black, Puerto Rican and Hispanic Legislative Caucus**

Health Care Disparities Between Minorities and Non-Minorities

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In March 2004, the Center for Justice & Democracy released a new study entitled *“Tort Reform” and Racial Prejudice: A Troublesome Connection*. This study examined how racial issues have been used and often concealed by the rhetoric of the “tort reform” movement and how “tort reform” proposals have a disparate impact on racial and ethnic minorities.

Several of the report’s findings are particularly relevant to today’s hearing. First, the report found that because racial and ethnic minorities are more likely to receive negligent medical care, limits on the rights of patients who have been killed or injured due to medical malpractice, as is being pursued by the insurance and medical lobbies, disproportionately hurt these groups. Second, so-called “tort reform” groups, and specific government proposals, have specifically targeted juries for attack in communities where the populations are primarily racial and ethnic minorities, including New York City.

As a result of the release of this study, members of the Congressional Black Caucus issued statements expressing tremendous concern over its findings. Rep. John Conyers (D-Mich.), the ranking Democrat on the House Judiciary Committee, said, “The dirty little secret of the so-called tort reform movement is that it is premised on racist notions, and would have a massively disproportionate impact on African Americans, Hispanics and other minorities.... The restrictions on non-economic damages included in the Republican medical malpractice [bill] will also have a severe and disproportionate impact on minorities.”

Congresswoman Sheila Jackson Lee (D-Tex.) said, “In looking at the disparate impact that the new tort reform laws will have on ethnic minority groups, it is unconscionable that the burden will be placed on these groups – that are in the worst position to bear the liability costs.... Over the next few decades, the United States will become more racially and ethnically diverse than it is today. Projections indicate that minority Americans-now approximately a quarter of the population-will comprise more than a third of all Americans by 2030. In certain areas of the country, such as New York City, racial and ethnic minorities will account for an even larger

share of the total population. Therefore, unless we act now as legislators to thwart these proposed reforms to our tort system, the principles of democracy – the very fiber of this nation’s existence – will be severely frustrated.”

The following are the report’s major findings as they relate to the topic of today’s hearing: health care disparities between minorities and non-minorities.

Medical Malpractice: The disproportionate impact of restrictions on patients’ legal rights on racial and ethnic minorities

In 1990, the Harvard Medical Practice Study evaluated New York hospitals and found that in the year studied – 1984 – 6,895 patients died and 27,177 patients were injured due to negligence by doctors and hospitals. Moreover, of these deaths and injuries, “there were significant differences between hospitals that serve a predominantly minority population and other hospitals. That is, blacks were more likely to be hospitalized at institutions with more AE’s [adverse events] and higher rates of negligence.”¹

Apparently, not much has changed since then. In 2002, the National Academy of Sciences Institute of Medicine (IOM) published its landmark study, entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, which was conducted at the request of Congress. According to Dr. Brian Smedley, director and co-editor of the report:

Importantly and perhaps foremost, we found that the health care playing field is not level. It is not level for minorities, many populations of color who, on average, receive a lower quality and intensity of health care. These disparities are found with consistency across disease areas, clinical services and settings.... Importantly, these disparities are associated with higher mortality among racial and ethnic minorities.²

In its earlier 1999 report, *To Err is Human: Building a Safer Health System*, IOM reported on one study which found that “[m]ore than two-thirds (70 percent) of adverse events...were thought to be preventable, with the most common types of preventable errors being technical errors (44 percent), diagnosis (17 percent), failure to prevent injury (12 percent) and errors in the use of a drug (10 percent).”³ Highly technical surgical specialties, such as cardiac surgery, contributed to higher rates of medical errors.⁴

In *Unequal Treatment*, after reviewing the most recent data available, IOM researchers found racial and ethnic differences in cardiovascular care and significant racial differences in the receipt of appropriate cancer diagnostic tests, treatments and analgesics, all of which led to higher death rates among minorities.⁵ Racial and ethnic disparities were also evident in diabetes care, end-stage renal disease and kidney transplantation, pediatric care, maternal and child health services and many surgical procedures.⁶ In some cases, minorities were more likely to receive less desirable procedures, such as amputation, than non-Hispanic whites.⁷

Other credible studies have uncovered evidence that race and ethnicity influence a patient’s chance of receiving specific procedures and treatments. For example, according to the Agency

for Healthcare Research and Quality (AHRQ), a division of the U.S. Department of Health and Human Services, the length of time between an abnormal screening mammogram and the follow-up diagnostic test to determine whether a woman has breast cancer is more than twice as long for Asian-American, African-American and Hispanic women as it is for white women.⁸

Moreover, as discovered by AHRQ, relative to non-Hispanic whites, racial and ethnic minorities are less likely to receive appropriate cancer care, cardiac care, diabetes care, pediatric care and many surgical procedures.⁹ In one AHRQ study, white patients were more likely than Hispanic and African-American patients to “receive invasive cardiac procedures in hospitals performing a high volume of such procedures, a factor strongly associated with the quality of cardiac care.”¹⁰ In other words, white patients are more likely to be treated in hospitals with experienced surgeons who are less likely to commit errors.

Racial prejudice may influence how minorities are treated by the health care industry. IOM researchers discovered that stereotyping, biases and uncertainty might play a role in medical disparities. Data showed that one-half to three-quarters of white Americans believe that minorities – particularly African-Americans – are less intelligent, more prone to violence and prefer to live off welfare compared to whites.¹¹ “In the United States, because of shared socialization influences,” says the IOM, “there is considerable empirical evidence that even well-meaning whites who are not overtly biased and who do not believe that they are prejudiced typically demonstrate unconscious implicit negative racial attitudes and stereotypes.”¹² (This group of “well-meaning whites” necessarily includes white healthcare providers, who, according to the IOM, may fail to recognize manifestations of prejudice in their own behavior.¹³)

It is clear that whatever the cause, racial and ethnic minorities are receiving inferior medical treatment by the health care industry and are being subjected to high rates of preventable medical errors.

The Health Insurance Factor

Complicating these issues is the fact that racial and ethnic minorities are uninsured more often than non-Hispanic whites, a status that frequently results in less than adequate care and poor health consequences.¹⁴ The Robert Wood Johnson Foundation reports that over 52 percent of Hispanics and more than 39 percent of African-Americans have no health insurance.¹⁵ The UCLA Center for Health Policy Research and the Kaiser Family Foundation recently found that over one-third of Latinos are uninsured, while nearly a quarter of African-Americans and about one-fifth of Asian-Americans and Pacific Islanders have no health coverage.¹⁶ In addition, these researchers discovered that the uninsured rate for African-Americans is more than 50 percent higher compared to non-Hispanic whites.¹⁷ Similarly, AHRQ found that nearly one-third of all Hispanics and one-fifth of all African Americans were without health insurance in early 1998, compared with 12.2 percent of non-Hispanic whites that same year.¹⁸

Minorities without health insurance are far more likely than are white Americans to rely on hospitals for their usual source of care, where medical errors are substantial.¹⁹ In its 1999 study, IOM extrapolated the figures found in the Harvard Medical Practice Study and other hospital studies and made some striking findings about the poor safety record of U.S. hospitals due to

preventable medical errors. IOM concluded that between 44,000 and 98,000 people are killed each year by medical errors in hospitals – far more than those who die from car accidents, breast cancer or AIDS.²⁰

Another study cited by IOM found that the hospital unit with the highest proportion of negligent adverse events (52.6 percent) was the emergency department, where people without health insurance may go for primary care.²¹ In addition, uninsured persons with traumatic injuries are less likely than those with insurance to be admitted to the hospital, receive fewer services if they are and are more likely to die.²² A study released by the Robert Wood Johnson Foundation in March 2003 reached similar conclusions, namely that compared with the insured, those without health coverage who are hospitalized are more likely to receive fewer services, experience second-rate care and die in the hospital.²³

Even when they do have health insurance, racial and ethnic minorities tend to be enrolled in “lower-end” health plans more often than non-Hispanic whites, a fact that often translates into substandard care since such plans have higher per capita resource constraints and stricter limits on covered services.²⁴ Lack of financial incentives for healthcare providers also plays a role, with low payment rates limiting the supply of providers to low-income groups and fostering an unwillingness among providers to spend adequate time with patients, disproportionately affecting minorities.²⁵

Limits on Non-Economic Damages

New York bills A. 9599 and S. 469A – containing the medical and insurance lobbies’ wish list – includes, among other things, an arbitrary \$250,000 ceiling, or cap, on the amount a patient injured by medical negligence could receive for non-economic damages, no matter how devastating the injury or egregious the malpractice.

Non-economic damages compensate for intangible but real injuries like infertility, permanent disability, disfigurement, blindness, pain and suffering, loss of a limb or other physical impairment. Any limit on non-economic damages has a disproportionate impact on low wage-earners who are more likely to receive a greater percentage of their compensation in the form of non-economic damages if they are injured. In other words, caps on non-economic damages disproportionately affect minorities, children, the elderly and spouses who do not work outside the home.

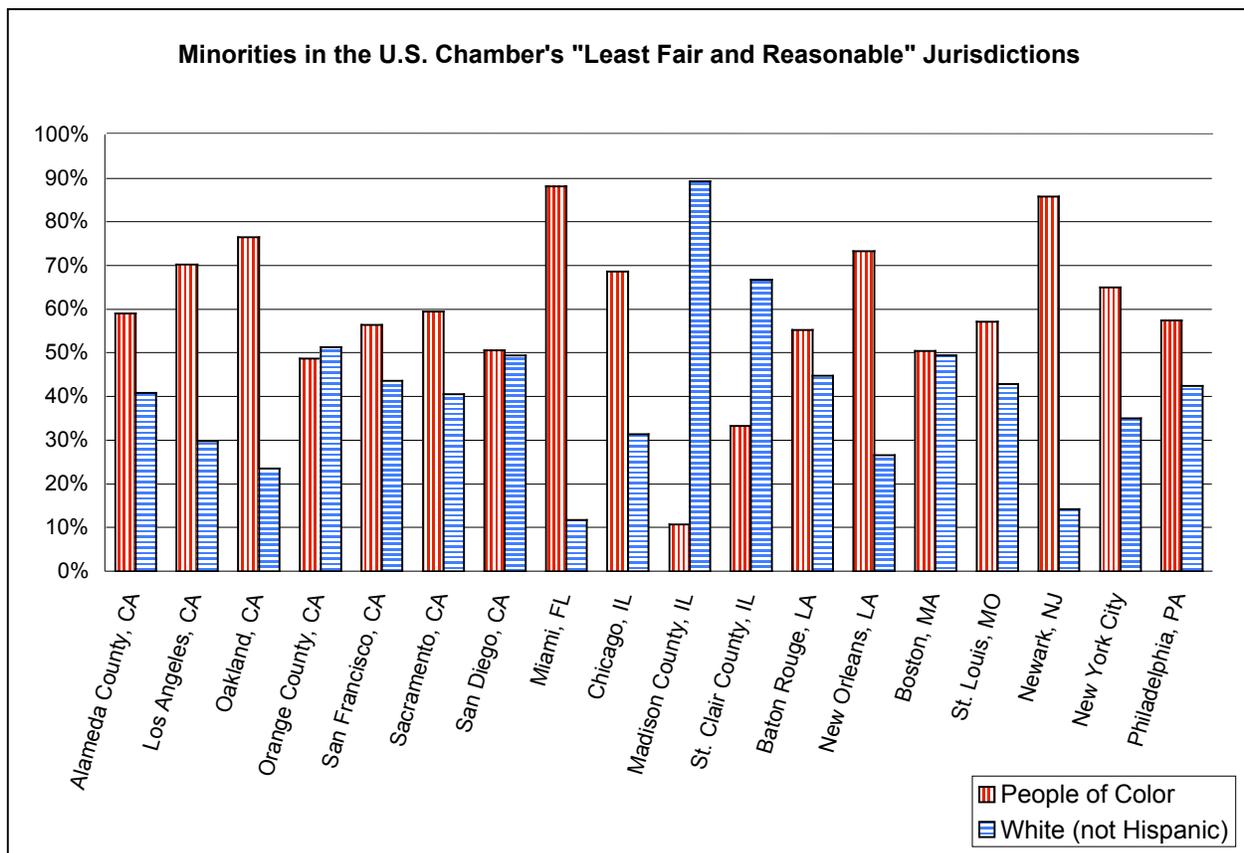
In sum, racial and ethnic minorities receive inferior medical treatment by the health care industry and are being subjected to high rates of preventable medical errors. As a result, limits on the rights of patients who have been killed or injured due to medical malpractice will disproportionately hurt racial and ethnic minorities. Complicating these issues is the fact that racial and ethnic minorities are uninsured more often than non-Hispanic whites, a status that frequently results in less than adequate care and poor health consequences. In addition, specific limits on non-economic damages, such as the \$250,000 caps being pushed by the medical and insurance lobbies, have a disproportionate impact on low wage-earners who are more likely to receive a greater percentage of their compensation in the form of non-economic damages if they are injured.

Attacks on New York Juries in Medical Malpractice Cases

A bill has surfaced in the Senate (S. 6715/S. 5395) that would expand jurisdiction of the Court of Claims, thereby abolishing jury trials for all medical malpractice claims brought against the Health and Hospitals Corporation. There is no valid public policy objective served by abrogating the right to jury trial in these cases.

Throughout recent history, certain special interest groups have specifically targeted juries in minority jurisdictions for relentless attacks, implying that juries in these jurisdictions are rendering unfair verdicts against undeserving corporations *not* because jurors have listened to the evidence in a case, but for other reasons – they are too poor, too uneducated, too “sympathetic” to the injured victim – even though the facts prove otherwise.

In March 2004, the U.S. Chamber of Commerce released its annual ranking of state liability systems, based on their survey of what corporate lawyers think of the U.S. “litigation environment.” This year, for the first time, the Chamber asked the corporate attorneys about which cities and counties they would identify as having “the least fair and reasonable litigation environment” (even though the Chamber stated in an earlier report that “to explore the detailed nuances within states would have required extensive questioning for each state and was beyond the scope and purpose of this study”). In 15 of the 18 jurisdictions targeted by the Chamber, the majority population is people of color. One of the 15 was New York City.



In their 2002 study “Trial Outcomes and Demographics: Is There a Bronx Effect?” Cornell University professors Theodore Eisenberg and Martin T. Wells decided it was time to actually examine facts about the “theory” that the Chamber “survey” tries to support. Eisenberg and Wells describe this “theory” as follows:

Minorities favor injured plaintiffs and give them inflated awards. This folk wisdom in the legal community influences choice of trial locale and the screening of jurors. A Los Angeles court is said to be known by local lawyers as “the bank” because of the frequency and size of its anti-corporate awards. A newspaper article summarizing court results suggests, somewhat jokingly, that the “Bronx County Courthouse should post a warning: People who get sued here run an increased risk of suffering staggering losses.”²⁶

When Eisenberg and Wells examined actual awards, they discovered that the conventional wisdom was wrong. Specifically, they found:

Although award levels and win rates differ significantly across geographic areas, these differences often do not uniformly reflect the folk wisdom about demographic influences. In federal court trials, we find no robust evidence that award levels in cases won by plaintiffs correlate with population demographics in the expected direction. Indeed, one persistent result is a negative relation between award levels and black population percentages.... In state court trials, we again find no robust evidence (at traditional levels of statistical significance) that race, income, or urbanization substantially help explain award levels.²⁷

Professor Neil Vidmar of Duke University, one of the country’s foremost jury experts, has done similar work dispelling myths about Mississippi juries in medical malpractice cases, finding “no evidence that Mississippi juries are out of control in medical malpractice cases or ... that they are different from juries in other parts of the country.”²⁸

A significant body of empirical evidence supports the view that civil juries are competent, responsible and rational, and that their decisions reflect continually changing community attitudes about corporate and professional responsibility.²⁹ The consensus among academics, judges and jurors themselves has always been that the system works extremely well. The erosion of this system by consistent attacks on juries by the Chamber of Commerce, other corporate special interests and certain public officials, is especially tragic given the growing dominance of corporate America in our lives.

Conclusion

It is a tragic and unfair fact of life that minorities are frequently forced to bear a disproportionately large share of New York’s health and safety problems. Whether it is inferior medical care, civil rights violations or any number of other indignities and injuries that juries are asked to evaluate every day, our civil justice system provides an essential tool to combat injustice in New York State.

Yet for the last 20 years, New York's insurance and health care industries have fought to undermine the civil justice system, particularly in the area of medical malpractice. Aimed in Albany's direction, this coalition of insurance companies and medical lobbies has attacked and, in the mid-1980s, succeeded in severely weakening decades of progress made by New York courts to ensure all of our citizens have their full legal rights.

Now these lobbies want more. They want bills like A. 9599/S. 469A, which would, among other things, cap non-economic damages for patients at \$250,000; and S. 5395, part of the Governor's program package that would eliminate the right to jury trial for any medical malpractice case against the Health and Hospitals Corporation.

These "tort reform" proposals, which have become the medical and insurance lobbies' number one legislative focus, would severely undermine the protections and rights afforded to racial and ethnic minorities in our state, and limit the power and authority of our juries.

The medical community's objectives should be deterring unsafe and substandard medical practices while safeguarding patients' rights instead of weakening the protections and rights afforded to New York's racial and ethnic minorities.

Notes

¹ Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990).

² Testimony of Dr. Brian Smedley during hearing with U.S. Representative Eddie Bernice Johnson (D-TX.) and the Asian-Pacific-American and Hispanic Caucuses on Health Disparities, April 12, 2002 (on file with CJ&D).

³ Kohn, Corrigan and Donaldson, eds., *To Err Is Human: Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, D.C. (1999), p. 30.

⁴ *Ibid.*

⁵ Smedley, Stith and Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002), Institute of Medicine, National Academy Press: Washington, D.C. (2002), p. 5.

⁶ *Ibid* at 5-6.

⁷ *Ibid.*

⁸ Agency for Healthcare Research and Quality, "Addressing Racial and Ethnic Disparities in Health Care" (February 2000), found at <http://www.ahrq.gov/research/disparit.htm>.

⁹ Agency for Healthcare Research and Quality, "Fiscal Year 2003: Research on Health Care Costs, Quality of Outcomes (HCQO)," found at <http://www.ahrq.gov/about/cj2003/hcqo03d.htm>; Agency for Healthcare Research and Quality, "AHRQ Focus on Research: Disparities in Health Care" (March 2002), found at <http://www.ahrq.gov/news/focus/disparhc.htm>; Agency for Healthcare Research and Quality,

“Addressing Racial and Ethnic Disparities in Health Care” (February 2000), found at <http://www.ahrq.gov/research/disparit.htm>.

¹⁰ Agency for Healthcare Research and Quality, “Addressing Racial and Ethnic Disparities in Health Care” (February 2000), found at <http://www.ahrq.gov/research/disparit.htm>.

¹¹ Smedley, Stith and Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Institute of Medicine, National Academy Press: Washington, D.C. (2002), p. 10.

¹² *Ibid.*

¹³ *Ibid.*

¹⁴ Families USA Foundation, *Going Without Health Insurance: Nearly One in Three Non-Elderly Americans* (March 2003), found at <http://www.familiesusa.org>; Center for Disease Control, *Health, United States, 2002*, found at <http://www.cdc.gov/nchs/hus.htm>; U.S. Census Bureau, *Health Insurance Coverage* (September 2000)(on file with CJ&D); Agency for Healthcare Research and Quality, “Hispanics and Black Americans Still More Likely than Whites To Be Uninsured,” August 2, 2000, found at <http://www.ahrq.gov/news/press/pr2000/meps98pr.htm>; Henry J. Kaiser Family Foundation and UCLA Center for Health Policy Research, *Racial and Ethnic Disparities in Access to Health Insurance and Health Care* (April 2000), found at <http://www.kff.org/content/2000/1525/UCLAReport.pdf>.

¹⁵ Families USA Foundation, *Going Without Health Insurance: Nearly One in Three Non-Elderly Americans* (March 2003), p. 7, found at <http://www.familiesusa.org>.

¹⁶ Henry J. Kaiser Family Foundation, “New Report Provides Critical Information About Health Insurance Coverage and Access for Racial and Ethnic Minority Groups,” August 1, 2001, found at <http://www.kff.org/content/2000/1525/UCLARelease.PDF>.

¹⁷ *Ibid.*

¹⁸ Agency for Healthcare Research and Quality, “Hispanic and Black Americans Still More Likely Than Whites To Be Uninsured,” August 2, 2000, found at <http://www.ahrq.gov/news/press/pr2000/meps98pr.htm>.

¹⁹ See, e.g., Sidney D. Watson, “Race, Ethnicity and Quality of Care: Inequalities and Incentives,” *27 Am. J. L. and Med.* 203, 205-6 (2001); Agency for Healthcare Research and Quality, “Addressing Racial and Ethnic Disparities in Health Care” (February 2000), found at <http://www.ahrq.gov/research/disparit.htm>.

²⁰ Kohn, Corrigan and Donaldson, Eds., *To Err Is Human; Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, D.C. (1999), p. 22.

²¹ *Ibid.* at 30.

²² Institute of Medicine, *Care Without Coverage: Too Little, Too Late* National Academy Press: Washington, D.C. (2002) p. 12.

²³ Families USA Foundation, *Going Without Health Insurance: Nearly One in Three Non-Elderly Americans* (March 2003), p. 15, found at <http://www.familiesusa.org>.

²⁴ Smedley, Stith and Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Institute of Medicine, National Academy Press: Washington, D.C. (2002), p. 13.

²⁵ *Ibid* at 16.

²⁶ Theodore Eisenberg and Martin T. Wells, "Trial Outcomes and Demographics: Is There a Bronx Effect?," 80 *Tex. L. Rev.* 1839 (June 2002).

²⁷ *Ibid* at 1839-1840.

²⁸ Neil Vidmar and Leigh Anne Brown, *Tort Reform and the Medical Liability Insurance Crisis in Mississippi: Diagnosing the Disease and Prescribing a Remedy*, November 17, 2002, p. 12 (on file with CJ&D).

²⁹ See, e.g., "Juries on Trial: Federal Judge Survey," *Dallas Morning News*, May 7, 2000 (survey results on file with CJ&D); Valerie Hans, *Business on Trial: The Civil Jury & Corporate Responsibility*. New Haven and London: Yale University Press (2000); Marc Galanter, "Real World Torts: An Antidote to Anecdote," 55 *Md. L. Rev.* 1093, 1109, note 45 (1996), citing Michael J. Saks, *Small-Group Decision Making and Complex Information Tasks* (1981); Robert MacCoun, "Inside the Black Box: What Empirical Research Tells Us About Decisionmaking by Civil Juries," in *Verdict: Assessing the Civil Jury System* 137 (Brookings Institution, Robert E. Litan ed., 1993); Richard O. Lempert, "Civil Juries and Complex Cases: Let's Not Rush to Judgment," 80 *Mich. L. Rev.* 68 (1981); Christy A. Visser, "Juror Decision Making: The Importance of Evidence," 11 *Law & Hum. Behav.* 1 (1987).