

# NOTES

## OUT OF THE FRYING PAN INTO THE FIRE: HEIGHTENED DISCRIMINATION & REDUCED LEGAL SAFEGUARDS WHEN PANDEMIC STRIKES

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*"Everybody was living in deadly fear because it was so quick, so sudden, and so terrifying."*

—Survivor of the 1918 Spanish Influenza<sup>1</sup>

When the H1N1 epidemic broke out in 2009, Wall Street banking corporations received shipments of the long-awaited vaccine ahead of unmet requests from many hospitals, cancer centers, pediatric offices and schools.<sup>2</sup> Officials defended allocation of the scarce resource, explaining that with thousands of providers and orders, distribution was not going very smoothly and that there may have been confusion regarding distribution.<sup>3</sup> Banking

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1. WGBH American Experience, *Influenza 1918*, PBS, <http://www.pbs.org/wgbh/americanexperience/features/introduction/influenza-introduction/> (last visited Mar. 27, 2011).

2. Jenny Anderson, *Officials Defend Distribution of Flu Vaccine to Companies*, N.Y. TIMES, Nov. 6, 2009, at A28; Esmé E. Deprez, *New York Businesses Get H1N1 Vaccine*, BUSINESS WEEK, Nov. 2, 2009, [http://www.businessweek.com/bwdaily/dnflash/content/nov2009/db2009112\\_606442.htm](http://www.businessweek.com/bwdaily/dnflash/content/nov2009/db2009112_606442.htm); Andrew Clark, *Wall Street Bankers at Front of Queue for Scarce Swine Flu Vaccine*, GUARDIAN, Nov. 6, 2009, <http://www.guardian.co.uk/business/2009/nov/06/wall-street-bankers-swine-flu>.

3. Anderson, *supra* note 2.

corporations were under a strict Center for Disease Control (CDC) mandate to distribute the vaccine only to high-risk individuals,<sup>4</sup> but many questioned why high-risk individuals on Wall Street should fare better than high-risk individuals on Main Street.<sup>5</sup> Despite the CDC's prioritization guidelines, the confused and seemingly ad-hoc distribution system resulted in inequity or—at best—chance benefit to privileged groups.

During a more severe pandemic, scarce resources and ad-hoc, understaffed emergency response systems may result in far greater inequities impacting underprivileged citizens.<sup>6</sup> This paper focuses on the particular susceptibilities of racial and ethnic minorities, because of the complex forms of discrimination these minorities already face in our healthcare system.<sup>7</sup>

Specifically, this paper argues that some legal rights and remedies that indirectly restrain discriminatory behavior under normal circumstances will likely be reduced or removed during emergency responses to a deadly pandemic.<sup>8</sup> Of particular concern is the potential impact of reducing these legal safeguards against discrimination at a time when prejudices may be heightened, resources will likely be scarce, and safeguards will be most needed.<sup>9</sup> Any resulting discrimination could be devastating, given the likelihood that a pandemic may prove far deadlier to minority groups.<sup>10</sup> Early data shows that African Americans, Latinos, and Native Americans are 150%–200% more likely to die from H1N1 than European Americans.<sup>11</sup>

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4. Deprez, *supra* note 2.

5. Clark, *supra* note 2.

6. See Sharona Hoffman, *Preparing for Disaster: Protecting the Most Vulnerable in Emergencies*, 42 U.C. DAVIS L. REV. 1491 (2009) [hereinafter Hoffman, *Preparing for Disaster*]; David A. Farber, *Disaster Law and Inequality*, 25 LAW & INEQ. 297, 303–04 (2007).

7. See *infra* Part I.B; see generally UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley et al. eds., 2003) [hereinafter UNEQUAL TREATMENT]. Notably, other complex factors such as SES and healthcare access largely contribute to racial and ethnic disparities in the health care system and will likely cause inequities during a pandemic. See Hoffman, *Preparing for Disaster*, *supra* note 6. However, socioeconomic status and access to healthcare fail to fully account for the disparate treatment racial and ethnic minorities receive in our healthcare system. See *infra* notes 34–41 and accompanying text; see also *Eliminating Health Disparities*, AMERICAN MEDICAL ASSOCIATION, <http://www.ama-assn.org/ama/pub/physician-resources/public-health/eliminating-health-disparities.shtml> (last visited Feb. 13, 2011). Pandemic planning should address disparities on all fronts, but this article calls for recognition of the particular legal implications and susceptibilities that might arise surrounding issues of racial and ethnic discrimination.

8. See *infra* Part II.A.

9. See *infra* Parts II.B.–C.

10. Sandra Crouse Quinn et al., *Racial Disparities in Exposure, Susceptibility, and Access to Health Care in the U.S. H1N1 Influenza Pandemic*, 101 AM. J. PUB. HEALTH 285 (2011).

11. See Molly Hennessy-Fiske, *Latinos and Blacks in California More Likely to Die of H1N1 Than Whites*, L.A. TIMES, Jan. 14, 2010, <http://latimesblogs.latimes.com/lanow/2010/01/latinos-and-blacks-in->

In Section I, this paper will uncover the complex types of ethnic and racial discrimination that exist today, as well as the current state of discrimination in healthcare. Section II discusses the likelihood that, when a severe pandemic strikes, the government will reduce or eliminate legal safeguards that protect against unconscious and inadvertent discrimination. The section also discusses how these legal safeguards will be needed more than ever during a pandemic, because of severe resource shortages, ad-hoc decision-making, and the societal phenomenon of racial “scapegoating.” Finally, Section III recommends that, considering the government’s interventionist approach to pandemic response and coordination, it should replace the legal protections that will be reduced with other safeguards against discrimination.

#### I. THE FRYING PAN: RACIAL & ETHNIC DISCRIMINATION IN MEDICAL TREATMENT & RESOURCE ALLOCATION

The American Medical Association recognizes that “[Racial and ethnic d]isparities in health care exist even when controlling for gender, [health] condition, age and socio-economic status.”<sup>12</sup> The threat of a pandemic is greatest to minorities for reasons rooted in America’s prejudiced past. Minority groups face large socioeconomic hurdles, as well as entrenched, often-complex forms of discrimination in obtaining health services.<sup>13</sup> This section discusses the complex types of discrimination that are common today, and then addresses discrimination in healthcare, effecting disparate treatment that cannot be explained by healthcare access, education, income, age, gender, health condition, symptoms presented, or patient preference.<sup>14</sup>

##### *A. Understanding Twenty-First Century Discrimination*

Racial disparities not attributable to socio-economic status may come as a surprise to many Americans, who largely conceptualize discrimination as a problem of the past.<sup>15</sup> This perception may have a lot to do with how people

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california-more-likely-to-die-of-h1n1-than-whites.html.

Note that this article uses the term “European Americans” rather than “Caucasian.” See Raj Bhopal & Liam Donaldson, *White, European, Western, Caucasian or What? Inappropriate Labeling in Research on Race, Ethnicity and Health*, 88 AM. J. PUB. HEALTH 1303 (1998).

12. See *Eliminating Health Disparities*, *supra* note 7.

13. See *infra* Part I.B.

14. UNEQUAL TREATMENT, *supra* note 7, at 2–4; see also *id.*

15. COMMITTEE ON NATIONAL STATISTICS, MEASURING RACIAL DISCRIMINATION 56 (Rebecca M.

define discrimination. Most Americans, especially European Americans, describe discrimination as overt, obvious, and individually perpetrated.<sup>16</sup> This definition of discrimination is in some ways reinforced by the law, which generally does not recognize more subtle forms of discrimination—except in some housing, lending, voting, or employment claims.<sup>17</sup> Otherwise, courts presiding over discrimination claims require plaintiffs to prove that there was an intent to discriminate or racial animus in order to successfully present their claims.<sup>18</sup>

Although courts generally require proof of intent, intentional discrimination is only the tip of the iceberg. The National Research Council has identified three other major types of discrimination.<sup>19</sup> Discrimination can be unconscious, can consist of statistical discrimination or profiling, and it can be perpetrated by statistics, systems, and institutions that focus on the needs of the majority to the exclusion of minorities.<sup>20</sup>

Unconscious discrimination is “a set of often unconscious beliefs and associations that affect the attitudes and behaviors of members of the ingroup (e.g., non-Hispanic whites) toward members of the outgroup (e.g., blacks or other disadvantaged racial groups).”<sup>21</sup> It may be manifested by positive feelings about one group—the preferred “in-group”—rather than negative feelings about another group.<sup>22</sup> Although few people exhibit explicit racism, the vast majority of those studied show signs of implicit or unconscious bias against minorities.<sup>23</sup> These behaviors have been well-documented and are pervasive regardless of a person’s level of educational achievement.<sup>24</sup> Even

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Blank et al. eds., 2004) (“Most people’s concept of racial discrimination involves explicit, direct hostility expressed by whites toward members of a disadvantaged racial group.”).

16. *Id.* at 55–56; see also Laurie T. O’Brien et al., *Understanding White Americans’ Perceptions of Racism in Hurricane Katrina-Related Events*, 12 GROUP PROCESSES & INTERGROUP REL. 431, 432 (2009).

17. COMMITTEE ON NATIONAL STATISTICS, *supra* note 15, at 40–41. Courts allow disparate impact claims, which recognize more subtle forms of discrimination, in housing, lending, voting and employment. See *infra* note 241. See *infra* note 244.

18. COMMITTEE ON NATIONAL STATISTICS, *supra* note 15, at 65–66.

19. *Id.* at 55–65.

20. *Id.*

21. *Id.* at 59; see also Irene V. Blair et al., *The Automaticity of Race and Afrocentric Facial Features in Social Judgments*, 87 J. PERSONALITY & SOC. PSYCHOL. 763 (2004).

22. COMMITTEE ON NATIONAL STATISTICS, *supra* note 15, at 60 (“The main effect of subtle prejudice seems to be to favor the ingroup rather than to directly disadvantage the outgroup; in this sense . . . [r]eactions need not be entirely negative to foster discrimination.”).

23. Univ. of Washington, *Test That Found Widespread Unconscious Racial Bias Validated*, SCI. DAILY, June 18, 2009, <http://www.sciencedaily.com/releases/2009/06/090617142120.htm>.

24. *Id.* (discussing the results of hundreds of studies); Stephen Smith, *Tests of Trainee Doctors Find*

minority individuals may exhibit this preference towards the “in-group,” by favoring those who are lighter skinned, a problem described as “colorism.”<sup>25</sup>

Similarly, statistical and institutional discrimination may not involve any intentional ill-will towards minority groups. Statistical discrimination, or profiling, occurs when a person “is treated differently because of information associated with his or her racial group membership.”<sup>26</sup> For example, if a person believes that certain minority groups are more likely to exhibit criminal behavior, he or she may attribute criminality to a specific individual from that group.<sup>27</sup> People might also make assumptions about a person’s education, abilities, health, or habits based on perceptions of average or typical characteristics of the person’s racial or ethnic group.<sup>28</sup> The practice may be exacerbated by the tendency to see minorities based on racial, rather than individual attributes.<sup>29</sup> The result is that a minority individual may have to work harder, achieve more, say more, or stand out more to overcome this assumptive profiling and be treated like an average member of the majority group.<sup>30</sup>

Institutional discrimination is even more complex. Factors which appear to be neutral may be applied selectively.<sup>31</sup> For example, an irregular credit history that might be brushed aside in granting a loan to a white borrower might not be waived for an African American or Latino.<sup>32</sup> Another issue is that neutral factors developed with only the majority in mind could fail to account for the different needs or characteristics of minority groups. For example, donor kidneys were originally allocated disproportionately based on blood antigens, without regard to the fact that antigens show differently in African Americans.<sup>33</sup>

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*Signs of Race Bias in Care*, BOSTON GLOBE, July 20, 2007, [http://www.boston.com/news/local/articles/2007/07/20/tests\\_of\\_er\\_trainees\\_find\\_signs\\_of\\_race\\_bias\\_in\\_care/](http://www.boston.com/news/local/articles/2007/07/20/tests_of_er_trainees_find_signs_of_race_bias_in_care/) (“Years of advanced education and egalitarian intentions are no protection against the effect of implicit attitudes[.]”).

25. Richard D. Harvey et al., *The Intragroup Stigmatization of Skin Tone Among Black Americans*, 31 J. BLACK PSYCHOL. 237, 237–38 (2005); Shankar Vedantam, Op-Ed., *Shades of Prejudice*, N.Y. TIMES, Jan. 18, 2010, <http://www.nytimes.com/2010/01/19/opinion/19vedantam.html>.

26. COMMITTEE ON NATIONAL STATISTICS, *supra* note 15, at 62.

27. *Id.* at 61; Deborah A. Ramirez et al., *Defining Racial Profiling in a Post-September 11 World*, 40 AM. CRIM. L. REV. 1195, 1195–96 (2003) (discussing the widespread justification following the September 11, 2001 terror attacks of using race to signal criminality).

28. COMMITTEE ON NATIONAL STATISTICS, *supra* note 15, at 61–63.

29. *Id.* at 61–62; see also Tracey Owens Patton & Julie Snyder-Yuly, *Any Four Black Men Will Do: Rape, Race, and the Ultimate Scapegoat*, 37 J. BLACK STUD. 859, 872–74 (2007).

30. *Id.* at 64.

31. *Id.*

32. *Id.*

33. Larry J. Pittman, *A Thirteenth Amendment Challenge to Both Racial Disparities in Medical*

*B. Discrimination in the Healthcare System and in Resource Allocation*

Minority individuals are treated differently than European Americans in our healthcare system due to these complex forms of discrimination. Racial and ethnic minorities receive lower quality health services, less frequent screenings and procedures, reduced and delayed treatment, and experience higher mortality rates than European Americans.<sup>34</sup> Socioeconomic status only partially explains the problem.<sup>35</sup> Although the first and primary barrier that many minority citizens face in receiving medical treatment is the “ability to gain entry to the healthcare system[,]” it is not the only one.<sup>36</sup> Numerous racial and ethnic disparities exist in patient prognoses, diagnoses, and treatment, even after controlling for socioeconomic factors and access to healthcare.<sup>37</sup>

The race or ethnicity of a patient often affects the healthcare treatment he or she will receive, even when controlling for income, education, gender, age, healthcare access, and health condition.<sup>38</sup> This is the case when it comes to numerous types of healthcare, including cancer treatments, cardiac medication, coronary artery bypass surgery, peritoneal dialysis, intensive care, emergency room care, and even prescription of pain medication.<sup>39</sup> Similarly, African Americans are less likely to receive a scarce donor kidney than their similarly situated European American counterparts.<sup>40</sup> Physicians are also less

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*Treatments and Improper Physicians’ Informed Consent Disclosures*, 48 ST. LOUIS U. L.J. 131, 141–42 (2003); see also R.S.D. Higgins & J.A. Fishman, *Disparities in Solid Organ Transplantation for Ethnic Minorities: Facts and Solutions*, 6 AM. J. TRANSPLANTATION 2556, 2557–58 (2006) (explaining that changed policy has improved the situation but discrepancies remain).

34. UNEQUAL TREATMENT, *supra* note 7, at 2–3, 5–6; René Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79, 85–86 (2001).

35. See *Eliminating Health Disparities*, *supra* note 7.

36. M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL’Y L. & ETHICS 95, 96 (2001).

37. UNEQUAL TREATMENT, *supra* note 7, at 2–4; Lu-in Wang, *Race as Proxy: Situational Racism and Self-Fulfilling Stereotypes*, 53 DEPAUL L. REV. 1013, 1083 (2004); Pittman, *supra* note 33, at 145.

38. See UNEQUAL TREATMENT, *supra* note 7; Bowser, *supra* note 34; see also *Eliminating Health Disparities*, *supra* note 7. Notably, differences in health *treatment* do not necessarily indicate differences in health *outcomes*. However, for purposes of this paper, and in the case of a pandemic where treatments such as ventilators may be vitally important to sustain life, it is sufficient to note the impact of discrimination on healthcare *treatment*.

39. UNEQUAL TREATMENT, *supra* note 7, at 2–5; William B. Millard, *Ignoring It Isn’t an Option: Racial Bias in Emergency Medicine*, 53 ANNALS EMERGENCY MED. 5:A19 (2009) (“When they control for all the associated confounding factors [in disparities in emergency department care] . . . the last thing remaining . . . is physician bias.”). Even patients’ communication of pain symptoms does not explain the problem. *Id.*

40. See Pittman, *supra* note 33, at 141–42.

likely to do simple blood-testing on minorities or to proscribe inexpensive medications that might prevent severe illness or death.<sup>41</sup>

This disparate resource allocation and medical treatment may be impacted by unconscious discrimination. Physicians and healthcare workers exhibit the same tendencies towards discrimination as the general population, with some admitting explicit bias and others claiming they are not prejudiced but still exhibiting signs of unconscious bias or discrimination.<sup>42</sup> Despite the fact that doctors report no *explicit* preference for white versus black patients, a recent study testing doctors' implicit bias showed that some doctors exhibit an unconscious bias against black patients. Furthermore, the greater the bias a physician exhibited in the test, the greater the likelihood that he would fail to offer black patients clot-busting treatment as compared to white patients.<sup>43</sup>

Actual or perceived resource shortages—such as time, personnel, or treatments—may exacerbate the problem of healthcare discrimination against racial and ethnic minorities.<sup>44</sup> Dr. Thomas Inui, who studies vulnerable patient groups, explained that unconscious discrimination surfaces “[w]hen we’re involved with high-pressure, high-stakes decision-making, when there’s a lot riding on our decisions but there isn’t a lot of time to make them, that’s when the implicit attitudes that are not scientific rise up and grab us.”<sup>45</sup>

Discrimination in healthcare treatment and allocation may also be caused by a combination of unconscious bias and other forms of discrimination, such as institutional discrimination, that fail to consider the needs of minorities. For example, African Americans might sometimes face unconscious discrimination by physicians who delay putting them on the kidney transplant list, and until quite recently, faced a second institutional discrimination hurdle since antigens, which show differently in African Americans, were used to match kidney recipients with donors.<sup>46</sup> Although antigen-matching is no longer used to prioritize kidney transplants, researchers and advocates had to

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41. Bowser, *supra* note 34, at 87.

42. Smith, *supra* note 24; Louis A. Penner, *Aversive Racism and Medical Interactions with Black Patients: A Field Study*, 46 J. EXPERIMENTAL SOC. PSYCHOL. 436, 436–38 (2010).

43. Alexander R. Green et al., *Implicit Bias Among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients*, 22(9) J. GEN. INTERN MED. 1231 (2007). The study incorporated the Implicit Association Test, which has proven highly accurate at predicting unconscious bias and even resulting behaviors. Univ. of Washington, *supra* note 23; *see also, e.g.*, Green et al., *supra*; *but cf.* Janice Sabin et al., *Physician Implicit Attitudes and Stereotypes About Race and Quality of Medical Care* 46(7) MEDICAL CARE 678 (finding that more research is needed to “explore whether physician implicit attitudes and stereotypes about race predict quality of care.”).

44. UNEQUAL TREATMENT, *supra* note 7, at 11–12.

45. Smith, *supra* note 24; *see also* UNEQUAL TREATMENT, *supra* note 7, at 11–12.

46. Pittman, *supra* note 33, at 139–42; Higgins & Fishman, *supra* note 33, at 2557–58.

work for over a decade to raise awareness and change the system.<sup>47</sup> Removal of this institutional discriminatory factor has improved the situation, but continued disparities suggest that African Americans still face the hurdle of physician discrimination in getting listed for a kidney transplant.

The compounded effect of several types of discrimination may cause disparities not only in *distributing* scarce healthcare resources, but also in *procuring* such resources. For example, institutional and unconscious discrimination may explain apparent disparities in involuntary cornea donations. Until recently, minorities may have been more likely to have their corneas harvested without their consent.<sup>48</sup> Presumed consent laws in many areas of the United States gave coroners the right to assume a deceased person's intent to donate their corneas in the absence of evidence otherwise.<sup>49</sup> These laws have been withdrawn in most states for a variety of reasons,<sup>50</sup> but while they existed, they seem to have resulted in both institutional and unconscious—or perhaps even overt—discrimination against minorities. Institutional discrimination resulted from presumed consent systems' proclivity to harvest from victims of violence (who are disproportionately minorities),<sup>51</sup> and "disparities may exist when coroners or medical examiners decide whether to retrieve organs or tissues from a dead person under their custody."<sup>52</sup>

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47. See, e.g., Ian Ayres, *Unequal Racial Access to Kidney Transplantation*, 46 VAND. L. REV. 805, 808–29 (1993) (discussing the disparities inherent in antigen-matching and suggesting alternatives; also noting earlier studies); Higgins & Fishman, *supra* note 33, at 2557–58 (antigen-matching criteria removed in 2003).

48. Michele Goodwin, *Deconstructing Legislative Consent Law: Organ Taking, Racial Profiling & Distributive Justice*, 6 VA. J.L. & TECH. ¶¶ 43–46 (2001).

49. David Orentlicher, *Presumed Consent to Organ Donation: Its Rise and Fall in the United States*, 61 RUTGERS L. REV. 295, 295 (2009).

50. *Id.* at 296–97.

51. Goodwin, *supra* note 48, at 7, 43–46; see also *id.* at 54 (“[T]hose more likely to be the donors under a traditional presumed consent law are people of color and the urban poor . . . placing the onus of such policies on the most fragile, rather than the most capable, seems inequitable and reminiscent of slavery.”).

52. Orentlicher, *supra* note 49, at 326. See also *id.* at 326–27 (“When the *Los Angeles Times* exposed the cornea retrieval practices of the county coroner, [it] found that that over 80% of the corneas came from blacks or Latinos even though only 44% of autopsies involved blacks or Latinos.”).



## II. INTO THE FIRE: THE REDUCTION OF LEGAL SAFEGUARDS, AMID RACIAL STIGMATIZATION AND RESOURCE SHORTAGES

During a pandemic, the government may take emergency actions that will likely have the unfortunate side effect of reducing legal safeguards against inadvertent discrimination. Although the extent to which discrimination might increase during a pandemic is unclear, this section argues that the reduction of legal safeguards might occur at a time when they might be most needed—amidst reduced resource shortages, ad-hoc decision-making, and possibly even racial “scapegoating.” The potential for heightened discrimination that might be caused by these compounded factors is troubling.

Government authorities are prepared to reduce liability and individual rights in order to maximize emergency response resources and contain the threat of pandemic.<sup>53</sup> Although these legal changes may be necessary and proper to save lives, we must not overlook the detrimental effect such actions will likely have on removing existing protections against discrimination.<sup>54</sup>

The reduction of legal safeguards is all the more disconcerting considering that the circumstances of a pandemic may heighten prejudices and increase the likelihood of discriminatory behaviors. People are more likely to discriminate and stigmatize racial or ethnic minorities out of fear when disease or terrorists strike.<sup>55</sup> Even those who do not participate in discriminatory behavior may empathize with those who do.<sup>56</sup> To further compound the problem, medical resources will likely be scarce, and the discrimination that already exists in the healthcare system may be magnified when there is not enough medical treatment to go around.<sup>57</sup> Additionally, rushed decision-making and distribution may result in reduced transparency and less public accountability.<sup>58</sup>

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53. See *infra* Part II.A.

54. *Id.*

55. See *infra* Part II.B.

56. See Muneer I. Ahmad, *A Rage Shared by Law: Post-September 11 Racial Violence as Crimes of Passion*, 92 CALIF. L. REV. 1259, 1295–1303, 1317–20 (2004).

57. Lawrence O. Gostin & Benjamin E. Berkman, *Pandemic Influenza: Ethics, Law, and the Public's Health*, 59 ADMIN. L. REV. 121, 149 (2007) (“Problems of fair benefits allocation arise under conditions of scarcity, where there is a competition for resources. This might occur, for example, with a scarcity of medical treatment in the midst of an influenza pandemic.”); Meir Katz, *Bioterrorism and Public Law: The Ethics of Scarce Medical Resource Allocation in Mass Casualty Situations*, 21 GEO. J. LEGAL ETHICS 795, 814–15 (2008) (discussing the importance of considering equality and vulnerable groups during a pandemic or bioterrorist attack).

58. See KENNETH R. WING, PUBLIC HEALTH LAW 265 (2007) (“[M]ost existing infectious disease statutes afford agencies broad discretion without setting clear standards for the exercise of power. This approach affords public health officials broad authority and makes it difficult to hold them accountable.”); Leland Ware, *Jim Crow on the “Down Low”: Subtle Racial Appeals in Presidential Campaigns*, 24 ST.

*A. Legal Safeguards Against Discrimination Will Likely Be Reduced*

Several important legal safeguards against discrimination may be reduced or eliminated as a result of governmental emergency response. Technically, equal protection rights prohibiting *intentional* discrimination will not be reduced (for example, claims brought under the Equal Protection Clause will not be eliminated),<sup>59</sup> but this section discusses how some protections against *unconscious* discrimination will be affected.

The Due Process Clause, which ensures that everyone's rights must be respected and that anyone can have a hearing before a government actor removes any rights, will apply differently since time and resources will be limited.<sup>60</sup> Although the CDC has recognized the need for any tradeoffs and procedures to be fair,<sup>61</sup> the reality is that the government will have an unprecedented compelling interest to infringe on substantive due process rights, and restrict citizens' right to life and liberty.<sup>62</sup> Limited time, personnel, and medical resources may result in reduced procedural due process if people are given short notice or little access to a meaningful hearing before they are confined or refused medical treatment.<sup>63</sup> With rights reduced, and courts likely working on a reduced staff while overwhelmed with requests for hearings,<sup>64</sup> injunctive relief may be difficult to obtain.

Additionally, tort remedies, which hold healthcare workers and institutions liable for neglect or mistreatment, will be difficult to obtain.<sup>65</sup>

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JOHN'S J. LEGAL COMMENT 299, 331 (2009) (discussing the importance of shedding light on subtle racism, stating "[u]nconscious racists engage in biased conduct when there are race-neutral justifications for their behavior, but they are less likely to discriminate when doing so would be obvious to themselves or others."); *see also infra* at 127–30.

59. *E.g.*, Title VI, 42 U.S.C. § 2000d (2006) *et seq.*, and equal protection under the Fourteenth Amendment. U.S. CONST. amend. XIV.

60. *See infra* Part II.C.1.

61. CDC ETHICS SUBCOMMITTEE OF THE ADVISORY COMMITTEE, ETHICAL GUIDELINES IN PANDEMIC INFLUENZA 4–6 (Feb. 15, 2007), [http://www.cdc.gov/od/science/phethics/panFlu\\_Ethic\\_Guidelines.pdf](http://www.cdc.gov/od/science/phethics/panFlu_Ethic_Guidelines.pdf).

62. *See* Lawrence O. Gostin, *When Terrorism Threatens Health: How Far Are Limitations on Personal and Economic Liberties Justified?*, 55 FLA. L. REV. 1105, 1106–10, 1131–37 (2003).

63. *See infra* Part II.A.1.

64. *See, e.g.*, NEW YORK STATE UNIFIED COURT SYSTEM & NEW YORK STATE BAR ASSOCIATION, NEW YORK STATE PUBLIC HEALTH LEGAL MANUAL: A GUIDE FOR JUDGES, ATTORNEYS AND PUBLIC HEALTH PROFESSIONALS 68–69 (2011) (discussing potential legal procedures for courts that might have to work with reduced personnel during public health emergencies), *available at* <http://www.nycourts.gov/whatsnew/pdf/PublicHealthLegalManual.pdf>.

65. *See infra* Part II.A.3.

Remedies will be limited, since emergency laws extend sovereign immunity to many workers, volunteers, organizations and agencies in order to increase emergency response.<sup>66</sup> Furthermore, the Emergency Medical Treatment and Labor Act (EMTALA), which prohibits emergency rooms from denying treatment to anyone, may even be suspended,<sup>67</sup> because during a deadly pandemic it simply may not be feasible to treat everyone with serious conditions.<sup>68</sup>

These reductions are legitimate and important tools in the effort to maximize pandemic response, and this paper does not contend that the changes are unnecessary or improper. Rather, this section argues that the reduction of legal rights, especially due process, could leave minority groups more vulnerable to discrimination at a time when they most need legal protection, and that other legal safeguards should replace those that will be eliminated.

Safety, security, and public health have always required some sacrifice of individual rights, but in a pandemic, the trade-off is likely to be far more severe than under normal circumstances.<sup>69</sup> Although the CDC has recognized the need for any tradeoffs and procedures to be fair,<sup>70</sup> the reality is that the government will have an unprecedented compelling interest to infringe on substantive due process rights, and restrict citizens' rights to life and liberty.<sup>71</sup> Limited time, personnel, and medical resources may result in reduced procedural due process if people are given short notice or little access to a

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66. *Id.*

67. *See infra* Part II.A.2.

68. William M. McDonnell, *EMTALA Disaster Rules and Pandemic H1N1 Influenza*, 30(11) AAP NEWS, Nov. 2009, at 16–17, available at <http://aapnews.aapublications.org/cgi/reprint/30/11/16>; Memorandum from Thomas E. Hamilton, Director of the Survey & Certification Group of the Center for Medicare & Medicaid Services, to State Survey Agency Directors, *Emergency Med. Treatment and Labor Act (EMTALA) Requirements and Options for Hospitals in a Disaster: Fact Sheet—Emergency Med. Treatment and Labor Act (EMTALA) & Surges in Demand for Emergency Dep't (ED) Services During a Pandemic*, Aug. 14, 2009, [http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09\\_52.pdf](http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09_52.pdf).

69. Gostin, *supra* note 62, at 1106–10, 1131–37; NEW YORK STATE WORKGROUP ON VENTILATOR ALLOCATION IN AN INFLUENZA PANDEMIC, NEW YORK STATE DEPARTMENT OF HEALTH & TASK FORCE ON LIFE & THE LAW, ALLOCATION OF VENTILATORS IN AN INFLUENZA PANDEMIC: PLANNING DOCUMENT 35–36, Draft for Public Comment, Mar. 15, 2007, [http://www.health.state.ny.us/diseases/communicable/influenza/pandemic/ventilators/docs/ventilator\\_guidance.pdf](http://www.health.state.ny.us/diseases/communicable/influenza/pandemic/ventilators/docs/ventilator_guidance.pdf) [hereinafter N.Y. STATE WORKGROUP ON VENTILATOR ALLOCATION].

70. CDC ETHICS SUBCOMMITTEE OF THE ADVISORY COMMITTEE, ETHICAL GUIDELINES IN PANDEMIC INFLUENZA, *supra* note 61, at 4–6.

71. Gostin, *supra* note 62.

meaningful hearing before they are confined or refused medical treatment.<sup>72</sup> With rights reduced and courts likely working with a reduced staff and overwhelmed with requests for hearings, injunctive relief may be difficult to obtain. Remedies will also be limited in *ex post facto* hearings, since emergency laws extend sovereign immunity to many workers, volunteers, organizations, and agencies in order to increase emergency response.<sup>73</sup>

In theory, these reductions in rights will apply to all citizens equally.<sup>74</sup> However, even if certain rights are not legally required, European Americans are more likely to be treated well, whether that means receiving higher quality healthcare or the benefit of the doubt in front of juries or law enforcement officers.<sup>75</sup> As Ayn Rand aptly put it, “the political function of rights is precisely to protect minorities from oppression by majorities.”<sup>76</sup> Thus, the reality is that legal reductions in rights will most affect minorities who are not as likely to reap the benefit of those rights without legal enforcement.<sup>77</sup>

### (1) *Reduced Due Process Safeguards*

The Due Process Clause is intertwined with Equal Protection and is essential in protecting minority rights because it ensures that everyone,

72. See generally *infra* notes 104–08.

73. See *infra* Part II.A.3.

74. See, e.g., CDC ETHICS SUBCOMMITTEE OF THE ADVISORY COMMITTEE, ETHICAL GUIDELINES IN PANDEMIC INFLUENZA, *supra* note 61, at 5.

75. See, e.g., Stephen B. Bright, *Discrimination, Death, and Denial: The Tolerance of Racial Discrimination in Infliction of the Death Penalty*, 35 SANTA CLARA L. REV. 433, 436 (1995) (discussing jury discrimination in death penalty cases); David A. Harris, *The Stories, the Statistics, and the Law: Why “Driving While Black” Matters*, 84 MINN. L. REV. 265, 302 (1999) [hereinafter Harris, *The Stories, the Statistics, and the Law*].

76. AYN RAND, *THE VIRTUE OF SELFISHNESS* 3, ch. 13 (New Am. Library, Penguin Group 1964). Similarly, American abolitionist Wendell Phillips stated that “Governments exist to protect the rights of minorities. The loved and the rich need no protection: they have many friends and few enemies.” WENDELL PHILLIPS, *SPEECHES, LECTURES, AND LETTERS* 341 (Boston, James Redpath 1863); see also James Madison, Speech in the Virginia Constitutional Convention (Dec. 2, 1829), in JAMES MADISON: WRITINGS 824 (Jack N. Rakove ed., 1999) (“In republics the great danger is, that the majority may not sufficiently respect the rights of the minority.”).

77. This concept is also recognized in international law, which emphasizes the important role that due process rights play in protecting minorities from discrimination. Inter-American Commission on Human Rights, Organization of American States, *Report on Terrorism and Human Rights* ¶¶ 246 (2002), <http://www.cidh.org/Terrorism/Eng/toc.htm> (“[D]ue process rights form an integral part of the judicial guarantees essential for the protection of non-derogable rights,” including non-discrimination. In fact, “no human rights supervisory body has yet found the exigencies of a genuine emergency situation sufficient to justify suspending even temporarily basic fair trial safeguards.”). See *supra* note 76. See also *infra* note 78 and accompanying text.

regardless of factors such as skin color, will be afforded certain fundamental rights and a fair hearing.<sup>78</sup> Unfortunately, however, the Due Process Clause will not provide the same substantive or procedural protections during a pandemic as it does under normal circumstances.<sup>79</sup> For example, the government interest in limiting the effects of a pandemic will likely be found sufficiently compelling to justify involuntary quarantine and isolation.<sup>80</sup> This is not to say that the due process analysis will change, but rather that the application will inevitably permit greater infringements and fewer procedural safeguards.

The dual danger to minorities is that their rights may be disproportionately infringed upon, and that with the reduction in process, minority individuals may be unable to get an injunction or restoration of those rights.<sup>81</sup> Reduced due process protections are especially concerning because due process applies to actions by many government organizations that will be active during a pandemic, including public health departments, the military, law enforcement, and local, state, and federal government entities, as well as public hospitals. Individuals seeking care from private hospitals are not necessarily provided due process protection,<sup>82</sup> but are provided with similar

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78. Gostin, *supra* note 62, at 1166 (“Procedural [due process] safeguards can be seen as a hedge against many of the wrongful actions of government such as arbitrary interference, individual discrimination, and group prejudice.”); Pamela S. Karlan, *Equal Protection, Due Process, and the Stereoscopic Fourteenth Amendment*, 33 McGEORGE L. REV. 473, 474 (2002) (“[T]he ideas of equality and liberty expressed in the equal protection and due process clauses each emerge from and reinforce the other.”). *See also* *Loving v. Va.*, 388 U.S. 1, 12 (1967). The court granted equal protection because it recognized marriage as a substantive due process right. (“To deny this fundamental freedom on so unsupportable a basis . . . so directly subversive of the principle of equality at the heart of the Fourteenth Amendment, is surely to deprive all the State’s citizens of liberty *without due process of law*.”) (emphasis added). *See also* William N. Eskridge, Jr., *Destabilizing Due Process and Evolutive Equal Protection*, 47 UCLA L. REV. 1183, 1183 (2000).

79. *See, e.g.*, Gostin, *supra* note 62; *Parham v. J.R.*, 442 U.S. 584, 608 (1979) (“What process is constitutionally due cannot be divorced from the nature of the ultimate decision that is being made.”); Franklin H. Alden, Jr., Note, *Liberty or Death: Maryland Improves Upon the Model State Emergency Health Powers Act*, 8 J. HEALTH CARE L. & POL’Y 185, 197 (2005) (“The [Model State Emergency Health Powers Act], through the doctrine of necessity, establishes the primacy of common defense interests of the state over the due process rights of citizens in the event of a health emergency.”).

80. *Supra* note 79.

81. It may also be difficult to receive later monetary damages under 42 U.S.C. § 1983 for any due process violations since federal and state triage guidelines say treatment may be denied or revoked. *West v. Atkins*, 487 U.S. 42, 50 (1988) (explaining that a § 1983 claim may only be made against a person who acts “under color of state law,” that is to say, one who “abuses the position given to him by the State.”); *see supra* note 75.

82. Private hospitals will only be subject to the due process clause if a court determines they are “state actors,” which may depend on a number of issues such as receipt of funding, regulation or inspection authority, leases, licensure, and more. Thomson Reuters, Annotation, *Action of Private Hospital as State*

protections under EMTALA, which might also be reduced or suspended during a pandemic.<sup>83</sup>

Substantive due process requires that the government cannot infringe upon any fundamental right unless it has a compelling reason to do so.<sup>84</sup> Fundamental rights, including the rights to life and liberty, are rarely revoked in cases not involving criminal or capital punishment.<sup>85</sup> However, national security and public health during a severe pandemic may provide a nearly insurmountable government interest that is sufficiently compelling to outweigh these fundamental rights.<sup>86</sup>

Thus far, no governmental interest has ever been found sufficiently compelling to infringe on the life of a conscious and protesting law-abiding citizen, who might recover if given treatment.<sup>87</sup> As noted in the CDC allocation guidelines, even the “withdraw[al] [of] life support from patients who lack decision-making capacity, have no surrogate, and have given no advance directives” is “controversial[.]”<sup>88</sup> However, many government emergency plans and guidelines as well as the CDC assume that withholding

*Action Under 42 U.S.C.A. § 1983 or Fourteenth Amendment*, 42 A.L.R. FED. 463, § 2, at 469–71 (2009).

83. See *infra* Part II.C.2.

84. *Reno v. Flores*, 507 U.S. 292, 301–02 (1993).

85. The government’s interest in preventing crime can be a sufficiently compelling reason to infringe on the fundamental right to liberty. *United States v. Salerno*, 481 U.S. 739, 749–50 (1987) (finding also, that the government’s interest in preventing crime sometimes allows for pre-trial detention); *Furman v. Ga.*, 408 U.S. 238, 359 n.141 (1972) (noting that the government does not automatically have a compelling interest in inflicting the death penalty, in a case striking down the death penalty as cruel and unusual punishment).

86. *Supra* note 79.

87. Some jurisdictions have statutes allowing physicians to make a decision to withdraw life support, but the decision is based on “medical futility” (e.g., brain death, or a coma with no hope of recovery) rather than because the government has some compelling interest in withdrawing the patient’s life support. Lois Shepherd, *Asking Too Much: Autonomy and Responsibility At the End of Life*, 26 J. CONTEMP. HEALTH L. & POL’Y 72, 74–76 (2009); Alicia Seibel, Comment, *The Limits to Life: What the D.C. Circuit’s Decision in Abigail Alliance v. Von Eschenbach Means for Medical Futility Statutes*, 53 ST. LOUIS U. L.J. 1321, 1324 (2009). The law is inconclusive, but it might also allow the unilateral termination of life support against the wishes of the patients’ family if physicians believe it is inhumane or otherwise against their ethical code to continue treatment. Patrick Moore, *An End-of-Life Quandary In Need of a Statutory Response: When Patients Demand Life-Sustaining Treatment That Physicians are Unwilling to Provide*, 48 B.C. L. REV. 433, 434 (2007). *But cf. In re Baby K.*, 832 F. Supp. 1022, 1030 (E.D. Va. 1993) (finding that termination of a minor’s life support against a parent’s wishes would violate due process rights of parents).

88. CDC VENTILATOR GUIDANCE WORKGROUP FOR THE ETHICS SUBCOMMITTEE OF THE ADVISORY COMMITTEE TO THE DIRECTOR, ETHICAL CONSIDERATIONS FOR DECISION MAKING REGARDING ALLOCATION OF MECHANICAL VENTILATORS DURING A SEVERE INFLUENZA PANDEMIC 19 (Oct. 30, 2009), [http://s3.amazonaws.com/propublica/assets/docs/Vent\\_Guidance\\_draftoc2008pdf.pdf](http://s3.amazonaws.com/propublica/assets/docs/Vent_Guidance_draftoc2008pdf.pdf) [hereinafter CDC VENTILATOR GUIDANCE WORKGROUP].

or revoking medical treatment—even removing a person from a life-sustaining ventilator without their consent—may become a necessity during a pandemic with severe medical resource shortages.<sup>89</sup> According to these guidelines, a compelling interest in reducing mass casualties (by allocating treatment to those most likely to survive) might warrant such infringements.<sup>90</sup> It is unclear how courts would view this infringement.<sup>91</sup> Nonetheless, the fact that the outcome is unclear shows that during a pandemic, substantive due process will tend not to protect the fundamental right to life nearly as unquestioningly as it does under normal circumstances.<sup>92</sup> Arguably, patients seeking care from private hospitals might not face any reduction in due process rights, if they would not have been entitled to due process rights in the first place.<sup>93</sup> However, as discussed in the next section, these patients' rights might be similarly reduced by a government suspension of EMTALA.<sup>94</sup>

Similarly, procedural due process may be limited due to time, personnel, and resource constraints. Procedural due process rights requiring notice and opportunity to be heard<sup>95</sup> will be especially important to ensure equality if the government determines it is necessary to infringe on citizens' rights during a pandemic.<sup>96</sup> This is because procedural due process provides assurance that if a healthcare right or entitlement becomes scarce and must be limited, it will be limited on a fair basis that is unrelated to race or ethnicity.<sup>97</sup> For example, recognizing their limited resources to prevent pandemic in the face of vaccine shortages, federal and state governments have begun dusting off the laws on

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89. See, e.g., Sheri Fink, *Your Chance to Weigh In on Ventilator Rationing for a Severe Flu Pandemic*, PROPUBLICA, Nov. 23, 2009, <http://www.propublica.org/feature/ventilator-rationing-for-a-severe-flu-pandemic-1122> (commenting regarding CDC ventilator guidelines “that mechanical ventilators could be disconnected from patients ‘whose prognosis has significantly worsened,’ regardless of their wishes, and provide those ventilators to ‘patients with a better prognosis.’”).

90. See Fink, *supra* note 89. See also *infra* notes 213–17 and accompanying text.

91. Courts might justify increased infringement on liberties by expanding the doctrine of medical futility. See *supra* note 88.

92. Under normal circumstances, the constitution does not permit a conscious protesting patient to be unilaterally denied medical treatment without their consent. See *supra* note 88. John D. Hodson, Annotation, *Judicial Power to Order Discontinuance of Life-Sustaining Treatment*, 48 A.L.R. 4th 67 § 2, at 73 (explaining that, assuming the state's interest in preserving life, courts thus far have predicated their decisions based on the best interests of the patient where it is deemed that the incapacitated patient would wish to be removed from treatment or life-support).

93. A private hospital is subject to the due process clause if it is considered a government actor. See Thomson Reuters, *supra* note 82, § 2, at 469–71.

94. See *infra* Part II.A.2.

95. *Fuentes v. Shevin*, 407 U.S. 67, 80 (1972).

96. See Gostin, *supra* note 62, at 1166.

97. *Id.*

quarantine.<sup>98</sup> If quarantines are invoked, procedural due process will be especially important for protecting minority rights. The laws are unclear and fractured since states and numerous federal agencies may execute quarantines under various authorities,<sup>99</sup> but generally the government must have evidence that the person is infectious or has been exposed to infectious disease and that they are likely to infect others.<sup>100</sup> Some courts have found that the government must justify quarantine by a showing that a person is dangerous or has engaged in dangerous conduct and is not likely to appropriately self-isolate.<sup>101</sup> Such a discretionary decision is open to abuse, and may pose an especial threat to the liberty of minority individuals who are more likely to be perceived as dangerous or criminal.<sup>102</sup> Some laws require a hearing, and the Constitution certainly requires it, but whether a hearing is actually granted may depend on the authority or statute under which a person is quarantined, and the urgency and extent of the crisis.<sup>103</sup>

Another procedural due process problem could arise since, if a person is deprived of medical treatment, it is unclear what notice and opportunity to be heard will be considered reasonable. Current triage guidelines generally suggest that the patient could simply be informed that he or she will not receive treatment,<sup>104</sup> or be given time to say goodbye to family members as

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98. See, e.g., Memorandum from Eric H. Holder, Jr., U.S. Attorney Gen., on Legal Authorities for Use in Response to an Outbreak of Pandemic Influenza, to the President of the U.S. (Apr. 25, 2009), [http://www.ncsl.org/Portals/1/Documents/health/attorneygeneral\\_flu.pdf](http://www.ncsl.org/Portals/1/Documents/health/attorneygeneral_flu.pdf).

99. David P. Fidler et al., *Through the Quarantine Looking Glass: Drug-Resistant Tuberculosis and Public Health*, 35 J.L. MED. & ETHICS 616, 620–21 (2007).

100. *Id.* at 622; see also *Ark. v. Snow*, 324 S.W.2d 532, 534 (Ark. 1959) (requiring a finding that infected individual is a danger to the public health); see also, e.g., *Application of Halko*, 54 Cal. Rptr. 661, 664 (Cal. Ct. App. 1966) (requiring infected individuals to be considered to be dangerous to public health).

101. See *City of Newark v. J.S.*, 652 A.2d 265, 275 (N.J. Super. 1993); Michael Corrado, *Punishment, Quarantine, and Preventive Detention*, 15 CRIM. JUST. ETHICS 3 (1996) (discussing the unreliability of determinations of dangerousness for purposes of quarantine).

102. W.E. Parmet, *Dangerous Perspectives: The Perils of Individualizing Public Health Problems*, 30 J. LEGAL MED. 83, 104 (2009) (“[M]ore often than not . . . the dangerous-patient perspective interacts with pre-existing prejudices and power imbalances, further stigmatizing and targeting individuals within already vulnerable and marginalized communities.”); Fidler et al., *supra* note 99, at 622 (“[G]overnments are sometimes tempted to use their quarantine powers as an instrument of prejudice against vulnerable individuals or populations.”); Ahmad, *supra* note 56, at 1278 (noting that in profiling schemes, “African American and Latino appearance has been equated with criminality”); David A. Harris, *Driving While Black: Racial Profiling on Our Nation’s Highways*, AMERICAN CIVIL LIBERTIES UNION SPECIAL REPORT (June 1999), <http://www.aclu.org/racial-justice/driving-while-black-racial-profiling-our-nations-highways>.

103. Parmet, *supra* note 102, at 621 (federal quarantine authority is arguably unconstitutional “because it does not give individuals subject to isolation or quarantine orders a right to a fair hearing”).

104. See Sheri Fink, *In Flu Pandemic, Florida’s Hospitals May Exclude Certain Patients*, PROPUBLICA (Oct. 16, 2009), <http://www.propublica.org/feature/in-flu-pandemic-states-hospitals-may->



well as perform any religious rituals before removal of life support.<sup>105</sup> It seems unthinkable that a person in the United States could be deprived of their life without a chance to at least argue their case in court. And yet, hospital triage guidelines do not mention any need for a triage officer to wait for a trial or its outcome before removing someone from a ventilator.<sup>106</sup> Given predicted shortages in a worst-case scenario, this may be realistic, but it is not clear whether the courts will determine that a decision by a team of doctors or the chance to plead with the triage officer will count as an “opportunity to be heard,” or—once again—the extent to which procedural due process will apply to a private hospital not considered a government actor.<sup>107</sup> The issue is that if courts determine that an actual trial before a judge is necessary, they may be flooded with representatives of patients who want to have their cases heard. Since the court system, like other institutions, may be operating with reduced personnel due to illness,<sup>108</sup> it is not clear to what extent hearings will be possible.

Due process “secures libertarian protections at the [individual] level that are important when the group is socially despised.”<sup>109</sup> Since minority individuals may be more likely to be refused medical treatment, quarantined, or have their rights otherwise infringed upon, any reduced protections of the due process clause may hit minority groups the hardest. At the very least, reduced protections remove an important safeguard against discrimination.

## *(2) Suspension of EMTALA*

Another safeguard against discrimination that might be reduced or lost during a pandemic is the Emergency Medical Treatment and Active Labor Act (EMTALA).<sup>110</sup> Under normal circumstances, EMTALA requires that a person with a serious medical condition, such as life-threatening influenza, have the

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exclude-certain-patients-1016.

105. CDC VENTILATOR GUIDANCE WORKGROUP, *supra* note 88, at 20.

106. *See, e.g., id.*; N.Y. STATE WORKGROUP ON VENTILATOR ALLOCATION, *supra* note 69, at 35–36 (stating that although the development of an appeals process would be preferable, it might not be feasible); Fink, *supra* note 89 (“Many of the states’ triage plans for pandemics do not envision seeking consent before ventilators are withdrawn.”).

107. *See supra* note 82.

108. *See* NEW YORK STATE UNIFIED COURT SYSTEM & NEW YORK STATE BAR ASSOCIATION, *supra* note 64.

109. William N. Eskridge, Jr., *Destabilizing Due Process and Evolutive Equal Protection*, 47 UCLA L. REV. 1183, 1183 (2000).

110. 42 U.S.C. § 1395dd (2006).

right to be admitted and stabilized in a hospital emergency room, and treatment may not be refused or revoked until the person is stable.<sup>111</sup> Nearly all hospitals are subject to EMTALA since it applies to any hospitals receiving Medicare funds.<sup>112</sup> However, the government may suspend EMTALA requirements that patients may not be turned away if it becomes impractical or impossible to place such a requirement on hospitals during a deadly pandemic.<sup>113</sup>

The suspension of EMTALA will doubtlessly affect European Americans as well as minorities, but it is important to recognize the different role that EMTALA plays for these groups. EMTALA ensures European Americans simply that they will receive treatment, and not be turned away based on socioeconomic factors. However, EMTALA provides an additional important assurance to minority individuals that they will not be turned away based on the color of their skin.<sup>114</sup>

EMTALA is an important safeguard against discrimination because it prohibits anyone with a serious medical condition from being turned away for any reason—no proof of intentional discrimination is required.<sup>115</sup> In effect, EMTALA prevents both inadvertent discrimination and discrimination which is purposeful but difficult to prove. If EMTALA is suspended, minority individuals whose treatment is refused or revoked will no longer be protected from being turned away based on discrimination that is subconscious, institutional, or even discrimination that is intentional but cannot be proven. These individuals will have to turn to Equal Protection and Title VI claims, which both require proof of discriminatory intent.<sup>116</sup> Injunctive relief, which requires that a claim must be likely to succeed, will be difficult to obtain.<sup>117</sup>

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111. *Id.*

112. Memorandum from Thomas E. Hamilton, *supra* note 68.

113. *Id.*; McDonnell, *supra* note 68, at 16–17.

114. Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J.L. & POL'Y 695, 711–13 (2006) (stating that EMTALA serves as an important safeguard in reducing both intentional and unintentional discrimination against minorities, especially because of the disproportionate emergency room use in minority communities).

115. See generally Jack E. Karns, *Hospital Screening Procedures and the Emergency Medical Treatment and Active Labor Act (EMTALA): Proof of "Improper Intent" Not Necessary in Failure to Stabilize Cases*, 9 WIDENER J. PUB. L. 355 (2000).

116. LU-IN WANG, DISCRIMINATION BY DEFAULT 133 (2006); see also John Arthur Laufer, Note, *Alexander v. Sandoval and Its Implications for Disparate Impact Regimes*, 102 COLUM. L. REV. 1613, 1614 (2003); UNEQUAL TREATMENT, *supra* note 7, at 627–28 (noting that Title VI is one of the principal legal tools in addressing discrimination in healthcare).

117. *Winter v. Natural Res. Def. Council*, 129 S. Ct. 365, 374 (2008).

### (3) Expanded Immunities and Reduced Tort Remedies

Sovereign immunity will likely be expanded during a pandemic to increase emergency response and absolve humanitarian actors from liability for circumstances beyond their control.<sup>118</sup> Unfortunately, expanded immunity may also have the detrimental effect of reducing safeguards against discrimination.<sup>119</sup>

Governmental immunity generally protects state and federal entities from being sued for damages or retroactive relief, unless they choose to waive the protection, and is usually available to state and federal officials, depending on the circumstances of the specific case.<sup>120</sup> Normally, immunity does not extend to local governments or to any entity not considered an arm of the state.<sup>121</sup> However, under the Public Readiness and Emergency Preparedness (PREP) Act, some immunity will also extend to civil suits against local government actors during a pandemic.<sup>122</sup>

Various federal laws also extend some form of immunity to government responders<sup>123</sup> and healthcare workers who volunteer during a pandemic,<sup>124</sup> as well as to entities and employees involved in the planning and distribution of pandemic “countermeasures” or qualified individuals, including healthcare workers, involved in the prescription, administration or dispensation of such

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118. Sharona Hoffman, *Responders' Responsibility: Liability and Immunity in Public Health Emergencies*, 96 GEO. L.J. 1917–18 (2008); James G. Hodge, Jr., *Legal Triage During Public Health Emergencies and Disasters*, 58 ADMIN. L. REV. 627, 640–42 (2006). For similar reasons, providers' standards of care may be altered. Eleanor D. Kinney et al., *Altered Standards of Care for Health Care Providers in the Pandemic Influenza*, 6 IND. HEALTH L. REV. 1, 8–9 (2009).

119. See Hoffman, *Preparing for Disaster*, *supra* note 6, at 1518, 1526, 1530–31 (discussing how the increased availability of immunities may prevent vulnerable populations from obtaining legal recourse).

120. Hoffman, *supra* note 118, at 1937–40.

121. See, e.g., *Alden v. Maine*, 527 U.S. 706, 740, 756 (1999) (discussing *Howlett v. Rose*, 496 U.S. 356, 375–76 (1990) and stating that entities such as municipal and local governments and school boards, which may be sued for constitutional violations under § 1983, cannot receive immunity as they are not an arm of the state).

122. Public Readiness and Emergency Preparedness (PREP) Act, 42 U.S.C.A. § 247d-6d(i)(2)-(7) (West 2010). PREP will likely reduce tort liability for local government actors. However, it is unclear whether this immunity will impact the analysis of § 1983 claims, which may normally be brought against municipal and local governments. See *id.* This is because § 1983 claims require proof that the actor misused or abused the law (acting “under color of law”), which would likely trigger the willful misconduct exception to PREP immunity in many cases, thus allowing at least some § 1983 claims to continue. See *Townsend v. Moya*, 291 F.3d 859, 861 (5th Cir. 2002) (explaining that a defendant acts “under color of state law” if he “misuses or abuses his official power”); 42 U.S.C.A. § 247d-6d(c) (West 2010) (willful conduct exception to PREP immunity).

123. Emergency Management Assistance Compact, Pub. L. No. 104-321, § 1, 110 Stat. 3877 (1996).

124. Volunteer Protection Act, 42 U.S.C.A. § 14503 (West 2010).

“countermeasures.”<sup>125</sup> Notably, healthcare workers who are not volunteers or who are not considered to be prescribing, administering, or dispensing countermeasures are not extended immunity by these federal laws, nor are private hospitals. However, a number of states extend immunity to any hospitals and healthcare workers involved in response,<sup>126</sup> and all states also grant varying degrees of immunity to volunteers.<sup>127</sup>

The immunity that will apply differs depending on the law involved. However, most laws will provide immunity for ordinary negligence as long as a person has acted in good faith, but make exceptions for gross negligence or for wanton or willful misconduct.<sup>128</sup> Since they will not be liable for ordinary negligence, covered physicians and other healthcare workers will have greater discretion and wider latitude to depart from accepted norms. They will only be held liable for deviations that are sufficiently severe to be considered grossly negligent, or sufficiently obvious that any misconduct could be proven willful. Of course, the extent of discretion they are granted may depend on whether the entity they are working under is also provided immunity. Nonetheless, healthcare workers who would not be afforded immunity under normal circumstances will receive immunity if they volunteer in a pandemic (or if they are working in some other covered capacity) and may feel that they have wider latitude in how they administer care.

Unfortunately, minority individuals may be more vulnerable to discrimination if covered physicians and healthcare workers are granted more discretion and wider latitude in decision-making.<sup>129</sup> People who are likely to have their work scrutinized, publicized, or made accountable are less likely to discriminate, even subconsciously.<sup>130</sup> Lack of accountability and unbridled

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125. Public Readiness and Emergency Preparedness (PREP) Act, 42 U.S.C.A. § 247d-6d (West 2010); Hoffman, *supra* note 118, at 1943–44.

126. Hoffman, *supra* note 118, at 1947–48.

127. *Id.* at 1944–45.

128. 42 U.S.C.A. § 247d-6d(c) (West 2010); Hoffman, *supra* note 118, at 1947–48; Emergency Management Assistance Compact, *supra* note 123.

129. *See supra* note 58. Situations that call for rushed judgments, especially, may result in reliance on stereotypes as physicians are more likely ask leading questions, and “to interpret ambiguous information as confirming expectations[.]” and it may also “lead doctors unwittingly to prescribe . . . treatment choices that are less than optimal.” WANG, DISCRIMINATION BY DEFAULT, *supra* note 116, at 131; Bloche, *supra* note 36, at 103–04 (Because “race-related preconceptions” may affect clinical judgment, physician discretion in decisionmaking may result in unconscious discrimination.); Harris, *The Stories, The Statistics, and the Law*, *supra* note 75, at 302 (explaining how the expansion of police discretion has increased discriminatory behavior).

130. People “tend to pay more attention to individualized information . . . and to consider how external factors might be affecting their conduct . . . [when] they are motivated to make accurate judgments (as opposed to confirming their predictions) and when they are aware that their decisions will be compared

discretion allow unconscious discrimination to go unchecked and exacerbate its effects.<sup>131</sup> For example, organizations with “personnel systems whose criteria for making decisions are arbitrary and subjective are highly vulnerable to [unconscious] bias due to the influence of stereotypes—as . . . when individual managers have a great deal of discretion with little in the way of written guidelines or effective oversight.”<sup>132</sup>

As a result of extended immunities, it will also be more difficult to seek a remedy for any subconscious discrimination that leads to a covered physician’s negligence or mistreatment. Even under normal circumstances, a physician’s personal biases may lead to passive inattention towards the needs of certain minority individuals or groups.<sup>133</sup> In such cases, it would be difficult if not impossible to prove an equal protection claim, since the minority individual or group would have to show that the physician had the intent to discriminate.<sup>134</sup> However, the physician’s actions might normally be the basis for a malpractice claim, or at least a negligence claim. Thus, if doctors are granted immunity during a pandemic, patients and their families who are unable to prove the doctor had an intent to discriminate may be left with little recourse. They would have to prove that the doctor was grossly negligent or willfully engaged in misconduct.<sup>135</sup> Thus, expanding available immunities will likely reduce yet another important safeguard against discrimination.

### *B. Fear and Racial Scapegoating*

The reduction of legal safeguards during a pandemic is all the more troubling because of the danger that racial prejudices will be heightened through a phenomenon sometimes referred to as racial “scapegoating.”<sup>136</sup>

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to objective criteria.” WANG, DISCRIMINATION BY DEFAULT, *supra* note 116, at 143–44. Accord George J. Annas et al., *Pandemic Preparedness: The Need for a Public Health—Not a Law Enforcement/National Security—Approach*, AMERICAN CIVIL LIBERTIES UNION 24 (2008), [http://www.aclu.org/pdfs/privacy/pemic\\_report.pdf](http://www.aclu.org/pdfs/privacy/pemic_report.pdf) (“The prospect of accountability is often the only check on temptations to act unjustly during emergencies”). See also *supra* notes 58, 129.

131. William T. Bielby, *Minimizing Workplace Gender and Racial Bias*, 29 CONTEMP. SOC. 120, 123–26 (2000).

132. *Id.* at 123.

133. See *supra* Part I.B.

134. The burden in proving intentional discrimination is high, and especially difficult to establish in medical situations where physicians can point to any number of complex factors upon which a decision was based. WANG, DISCRIMINATION BY DEFAULT, *supra* note 116, at 133–34.

135. 42 U.S.C.A. § 247d-6d(c) (West 2010); Hoffman, *supra* note 118, at 1947–48; Emergency Management Assistance Compact, *supra* note 123.

136. MICHAEL WELCH, SCAPEGOATS OF SEPTEMBER 11TH: HATE CRIMES & STATE CRIMES IN THE

When people's deepest fears are incited, their conscious and unconscious prejudices are likely to be magnified.<sup>137</sup> Notably, this "scapegoating" is often originally directed at immigrants, but also results in discrimination against anyone who looks like they could be from that group.<sup>138</sup> Thus, "scapegoating" tends to be directed at *perceived* race or ethnicity rather than nationality or any other *actual* demographic association.<sup>139</sup>

In past epidemics, people were quarantined based on ethnic origin,<sup>140</sup> and in fear of domestic terrorism, Americans of Japanese descent were forced to relocate to internment camps during a wartime threat from Japan.<sup>141</sup> Jewish immigrants were blamed for outbreaks of typhoid and cholera in New York.<sup>142</sup> During an outbreak of the bubonic plague in Chinatown in Hawaii in 1900, officials incinerated buildings without serving proper notice and relocated the occupants, mostly Asians, to quarantine camps.<sup>143</sup> When one Chinese American died mysteriously in San Francisco, a cruel quarantine was imposed on Chinatown on the suspicion that Chinese Americans might spread the bubonic plague.<sup>144</sup>

Luckily, we have not recently experienced pandemics as aggressive or deadly as those of a century ago. As a society, we have come a long way in improving civil rights and condemning practices such as racially-based quarantines or internment camps. However, scares of recent decades demonstrate that the practice of racial "scapegoating" nonetheless continues. Haitian immigrants were blamed for the spread of HIV in the 1980s,<sup>145</sup> and socially ostracized as one of the H's in "the 'Four H Club,'" a popular term referring to the four high-risk groups identified by the CDC: Haitians,

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WAR ON TERROR 3–5 (2006); Donald G. McNeil Jr., *Finding a Scapegoat When Epidemics Strike*, N.Y. TIMES, Sept. 1, 2009, at D1.

137. See generally HOWARD MARKEL, WHEN GERMS TRAVEL: SIX MAJOR EPIDEMICS THAT HAVE INVADED AMERICA SINCE 1900 AND THE FEARS THEY HAVE UNLEASHED (First Vintage Books 2005); Ronald Bayer, *Stigma and the Ethics of Public Health—Not Can We But Should We*, 67 SOC. SCI. & MED. 463 (2008).

138. McNeil, *supra* note 136; WELCH, *supra* note 136.

139. Ahmad, *supra* note 56, at 1278.

140. See *infra* notes 142–44 and accompanying text.

141. *Korematsu v. United States*, 323 U.S. 214 (1944).

142. See generally HOWARD MARKEL, QUARANTINE!: EAST EUROPEAN JEWISH IMMIGRANTS AND THE NEW YORK CITY EPIDEMICS OF 1892 (1997).

143. Felice Batlan, *Law in the Time of Cholera: Disease, State Power, and Quarantines Past and Future*, 80 TEMP. L. REV. 53, 98–99 (2007).

144. NAYAN SHAH, CONTAGIOUS DIVIDES: EPIDEMICS AND RACE IN SAN FRANCISCO'S CHINATOWN 120–22 (2001).

145. MARKEL, *supra* note 140, at 141–76.

homosexuals, hemophiliacs, and heroin-users.<sup>146</sup> This stigma was perpetuated by many in the healthcare industry who labeled Haitians as a high-risk group,<sup>147</sup> leading to the double-standard of Haitians being prohibited from donating blood, despite the fact that other populations with higher prevalence rates (e.g., populations of some U.S. cities) were not similarly prohibited.<sup>148</sup> In fact, the CDC eventually revealed that it did not actually have “HIV prevalence data on Haitian blood donors or on the Haitian-American population in the USA.”<sup>149</sup> The Federal Drug Association’s Blood Products Advisory Committee found that the result of this stigmatization was that “Haitians lost jobs, life and health insurance, and homes.”<sup>150</sup> A law prohibiting the emigration of HIV-positive individuals even led to the detention of HIV-positive Haitian refugees (and their non HIV-positive relatives) at Camp Bulkeley in Guantanamo from 1991 until a federal judge ordered its closure 1993.<sup>151</sup> Conditions were deplorable,<sup>152</sup> and led to the worsening health of many refugees and the death of at least one infant (who was not HIV-positive).<sup>153</sup>

In more recent years, people pointed the finger at Asian Americans during the SARs outbreak<sup>154</sup> and Latinos during the H1N1 epidemic.<sup>155</sup> For example,

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146. PAUL FARMER, *AIDS AND ACCUSATION: HAITI AND THE GEOGRAPHY OF BLAME* 211 (Univ. of California Press 2006) (1992). *See also id.* at 2 (“In 1982, U.S. public health officials inferred that Haitians *per se* were in some way at risk for AIDS,” and in a typical commentary “one reporter termed the incidence of AIDs in Haitians ‘a clue from the grave, as though a zombie, leaving a trail of unwinding gauze bandages and rotting flesh, had come to the hospital’s Grand Rounds to pronounce a curse.’”).

147. Charlene Galarneau, “*The H in HIV Stands for Human, Not Haitian*”: *Cultural Imperialism in US Blood Donor Policy*, 3 PUB. HEALTH & ETHICS 210, 212–13 (2010), <http://phe.oxfordjournals.org/content/3/3/210.full.pdf+html>.

148. *Id.* at 213.

149. *Id.* at 215.

150. *Id.*

151. MARKEL, *supra* note 137, at 166, 173.

152. One refugee reported:

We were in a space cordoned off with barbed wire. Wherever they put you, you were meant to stay right there; there was no place to move. The latrines were brimming over. There was never any cool water to drink, to wet our lips. There was only water in a cistern, boiling in the hot sun. When you drank it, it gave you diarrhea. . . . Rats crawled over us at night. . . . When we saw all these things, we thought, it’s not possible, it can’t go on like this. We’re humans, just like everyone else.

*Id.* at 168.

153. *Id.* at 168–71.

154. Laura Eichelberger, *SARS and New York’s Chinatown: The Politics of Risk and Blame During an Epidemic of Fear*, 65(6) SOC. SCI. & MED. 1284 (2007); Bobbie Person et al., *Fear and Stigma: The Epidemic Within the SARS Outbreak*, 10(2) EMERGING INFECTIOUS DISEASES 358 (2004).

155. Lawrence O. Gostin, *Influenza A (H1N1) and Pandemic Preparedness Under the Rule of International Law*, 301(22) J. AM. MED. ASS’N 2376, 2376 (2009) (explaining that in the wake of H1N1,

despite the relatively mild outbreak of H1N1 compared to major pandemics of the past, a study researching its effects on Latino farmworkers found that stigmatization against Latinos nonetheless occurred, reporting bullying, stigmatization by healthcare providers, shops telling Mexicans to keep out, and a school denying admission to children uninfected with H1N1, simply because those children had recently emigrated from Mexico.<sup>156</sup>

Although racially-based quarantines or internment camps in the case of a deadly pandemic or bioterrorist pandemic may seem highly unlikely today, racial scapegoating may nonetheless result in serious disadvantages to those who are perceived to be “at fault.” Experts observe that “[e]pidemics often bring out irrational fears and discriminatory behaviors among individuals and governments.”<sup>157</sup> Prejudice is unleashed because there’s a “fear of people we do not know or who look different.”<sup>158</sup> This “fear of the unknown that already exists . . . combine[d] . . . with a real or perceived threat that is contagious disease [is] explosive.”<sup>159</sup> When a person engages in racial “scapegoating,” she may be more likely to intentionally or inadvertently discriminate against others who are perceived to be members of the blamed racial group. Racial “scapegoating” might increase people’s likelihood to intentionally or inadvertently discriminate.<sup>160</sup> Like statistical discrimination, the practice of racial “scapegoating” may be exacerbated by the tendency to see minorities based on racial, rather than individual attributes.<sup>161</sup>

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“Mexicans have become subject to stigma and discrimination”); Anti-immigrant groups used the H1N1 outbreak as a platform to promote discrimination against Mexicans, and Latinos generally. See Brian Alexander, *Amid Swine Flu Outbreak, Racism Goes Viral: Anti-immigrant Hatred Spreads on Talk Radio, Web sites*, MSNBC.COM, May 1, 2009, <http://www.msnbc.msn.com/id/30467300/> (last visited Feb. 13, 2011).

156. Monica Schoc-Spana et al., *Stigma, Health Disparities, and the 2009 H1N1 Influenza Pandemic: How to Protect Latino Farmworkers in Future Health Emergencies*, 8 BIOSECURITY AND BIOTERRORISM: BIODEFENSE STRATEGY, PRACTICE, AND SCIENCE 243, 247–48 (2010), [http://www.upmc-biosecurity.org/website/resources/publications/2010/pdf/2010-09-15-stigma\\_disparities\\_h1n1.pdf](http://www.upmc-biosecurity.org/website/resources/publications/2010/pdf/2010-09-15-stigma_disparities_h1n1.pdf).

157. Gostin, *supra* note 155, at 2378.

158. Alexander, *supra* note 155 (quoting Dr. Howard Markel, medical historian at the University of Michigan).

159. *Id.*

160. People prefer to withhold scarce medical resources—such as organs—from those seen as blameworthy and distribute them instead to those seen as “innocent.” Robert G. Batey, *Denying Treatment to Drug and Alcohol-Dependent Patients*, 92(9) ADDICTION 1189, 1190 (2006) (Drug and alcohol dependent patients have often been targeted as individuals and as groups who should not be seen as having equal access to certain forms of therapy.); V. Thornton, *Who Gets the Liver Transplant? The Use of Responsibility as the Tie Breaker*, 35(12) J. MED. ETHICS 739, 739–41 (2009).

161. See *supra* note 29; Ramirez et al., *supra* note 27, at 1195–96 (there was widespread justification of using race to signal criminality following the 9/11 terror attacks); see also *infra* notes 164–66 and accompanying text.



Additionally, racial tensions may be heightened because, if and when a deadly pandemic strikes, we may not know for some time if it is the result of a bioterrorist attack or some naturally spread virus.<sup>162</sup> If the pandemic is perceived to be associated with terrorism, we can be sure that discriminatory behavior will ensue.<sup>163</sup> Hate crimes spiked following the events of September 11 as people turned on those who looked different, and perceived them as perpetrators of a threat.<sup>164</sup> While some individuals lashed out with hate crimes on hundreds, even thousands, of different occasions,<sup>165</sup> many others were empathetic to the deep feelings of fear and emotion and even to some hateful actions.<sup>166</sup> The government's practice of racial profiling both increased our sense of security and reinforced our racial fear and "scapegoating."<sup>167</sup>

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162. Kathleen F. Gensheimer et al., *Influenza Pandemic Preparedness*, 9(12) EMERGING INFECTIOUS DISEASES 1645, 1646 (2003) ("A rise beyond the baseline number of influenza-like illnesses (ILIs) could indicate a severe influenza season, arrival of pandemic influenza, or early warning of a bioterrorist attack with a pathogen that causes ILIs[.J]"); Julie A. Pavlin, *Epidemiology of Bioterrorism*, 5(4) EMERGING INFECTIOUS DISEASES 528, 528 (1999) ("Any small or large outbreak of disease should be evaluated as a potential bioterrorist attack. . . . The cause of a disease or even the occurrence of something unusual may be very difficult to determine.").

163. WELCH, *supra* note 136, at 35–45 (tracing the cultural and theoretical progression of racial scapegoating in the context of terror attacks and other "social crises").

164. *Id.* at 62–76; Ahmad, *supra* note 56, at 1265–66 (discussing the spike in hate crimes that occurred as "racial violence swept across the United States in the aftermath of September 11"); *id.* at 1278 (discussing the "fungibility" of "'Muslim-looking' People"); CNN, *Hate Crime Reports Up In Wake of Terrorist Attacks*, CNN.COM, Sept. 17, 2001; United States Department of Justice Civil Rights Division, *Enforcement and Outreach Following the September 11 Terrorist Attacks*, <http://www.justice.gov/crt/legalinfo/discrimupdate.php> (last modified Feb. 2, 2010) (discussing Department of Justice investigations into hate crimes following 9/11, involving "violence, threats, vandalism and arson against Arab-Americans, Muslims, Sikhs, South-Asian Americans and other individuals perceived to be of Middle Eastern origin").

165. Following the 9/11 terror attacks, numerous organizations reported that crime surges against Arab-Americans and Sikhs increased by as much as seventeen-fold with incident estimates ranging from over four hundred to nearly two thousand, and surveys of Muslims and Arab-Americans indicated that far more incidents likely went unreported due to gaps in the hate-crime reporting system. HUMAN RIGHTS WATCH, *"We Are Not the Enemy" Hate Crimes Against Arabs, Muslims, and Those Perceived to be Arab or Muslim after September 11*, 14(6)(G) HUMAN RIGHTS WATCH 15–16 (2002).

166. Acts of hate and prejudice were largely empathized with in the aftermath of September 11th, both by private citizens and governmental messages of fear and profiling. Ahmad, *supra* note 56, at 1295–99, 1317–20.

167. *Id.* at 1262 (discussing the "mutually reinforcing relationship between individual hate crimes and governmental racial profiling"); *id.* at 1320 ("Just as homosexual sodomy laws can be said to express 'the official 'theory' of homophobia,' racial profiling policies script a state theory of racial subordination. What is fundamentally different in the post-September 11 context, however, is that it is not only private citizens who put the state theory into practice. Rather, through its direct engagement in racial profiling, the state is an active participant in the process as well.").

Most people are not likely to commit hateful acts of violence, and concerted action against a racial or ethnic minority in today's society seems absurd, though a few have advocated for "dusting off" *Korematsu* and instituting racially-based quarantines.<sup>168</sup> What is more likely is that many individuals may discriminate, even subconsciously, if certain racial groups are perceived as "terrorists" or "disease carriers."<sup>169</sup>

Healthcare workers will be under immense psychological and emotional strain as the country faces an unprecedented situation,<sup>170</sup> and it is difficult to predict how they might subconsciously or intentionally react to such racial fears and "scapegoating." One hospital director described the strain when he had to turn patients away during a recent pandemic drill involving shortages of ventilators and hospital beds.<sup>171</sup> He said that "even with the scenarios played out and the discussions entertained, [the public participants] still d[id]n't understand[.]"<sup>172</sup> No real lives were at stake, but "mock patients and family members yelled, screamed and took issue with who was denied treatment."<sup>173</sup>

When a pandemic strikes, minority groups may be vulnerable to increased discrimination due to racial scapegoating. The aftermath of September 11 teaches us that such discrimination may be easy to rationalize because it is based on a fear that is widely-shared and may seem logical.<sup>174</sup> Scapegoating may also seem justified by the remote threat of governmentally-sanctioned discrimination that lingers as long as *Korematsu* remains law.<sup>175</sup> Safeguards against discrimination will be more important than ever, so any safeguards that must be reduced due to legal changes during a pandemic should be replaced with other legal and policy protections.

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168. See generally David Harris, *On the Contemporary Meaning of Korematsu: "Liberty Lies in the Hearts of Men and Women"* (U. of Pittsburgh Legal Studies Research Paper No. 2010-03, Feb. 16, 2010), available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1554084](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1554084); see also Eric K. Yamamoto et al., *American Racial Justice On Trial—Again: African American Reparations, Human Rights*, 101 MICH. L. REV. 1269, 1277–78 (2003).

169. See *supra* notes 29, 145–56, 163–66.

170. Fink, *supra* note 104.

171. *Id.*

172. *Id.*

173. *Id.*

174. See *supra* notes 29, 161–65.

175. *Korematsu v. United States*, 323 U.S. 214 (1944); see also *supra* note 167.

*C. Predicted Scarcities and the Accompanying Threat of Discrimination*

To make matters worse, governmental and medical authorities predict that a pandemic or bio-terrorist attack will likely be accompanied by major medical preventive and treatment shortages.<sup>176</sup> Since aggressive, high-tech, complex, time-consuming, and scarce medical resources are already less likely to go to minority individuals because of complex forms of discrimination,<sup>177</sup> it stands to reason that the situation could become worse when life-saving resources are further constricted during a pandemic or bioterrorist attack, especially if the tendency is exacerbated by racial “scapegoating.”<sup>178</sup> This section discusses how our nation’s emergency response system is especially vulnerable to increased racial and ethnic discrimination in the allocation and distribution of scarce medical resources.

Medical ethicists and authorities believe that since the threat of a pandemic or bioterrorist attack is an equally shared societal risk, prevention and treatment resources should be shared equally as well.<sup>179</sup> Risks that are borne individually (and that may bring individual profit), such as buying a house or skydiving, are generally insured individually. Additionally, individuals are generally responsible to deal with the consequences of their decisions.<sup>180</sup> Major disasters such as bioterrorist attacks or pandemics, on the other hand, are described as “social risks—those borne by everyone in a society,”<sup>181</sup> and thus, the distributive justice rationale employed by most

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176. CENTER FOR BIOSECURITY OF UPMC, THE NEXT CHALLENGE IN HEALTHCARE PREPAREDNESS: CATASTROPHIC HEALTH EVENTS (2010), <http://www.upmc-biosecurity.org/website/resources/publications/2010/pdf/2010-01-29-prepreport.pdf> (prepared for the U.S. Department of Health and Human Services).

177. See *supra* notes 39–40.

178. See *supra* Part II.A.

179. John G. Culhane, *What Does Justice Require for The Victims of Katrina and September 11?*, 10 DEPAUL J. HEALTH CARE L. 177, 177–78 (2007); Gostin & Berkman, *supra* note 57, at 148–49 (“In the context of public health, th[e] principle of [distributive justice] requires that officials act to limit the extent to which the burden of disease falls unfairly upon the least advantaged and to ensure that the burden of interventions themselves are distributed equitably . . . [It] does not merely require a fair allocation of risks and burdens . . . [but] benefits such as vaccines, treatment, or other services.”). See also, e.g., CDC ETHICS SUBCOMMITTEE OF THE ADVISORY COMMITTEE, *supra* note 61, at 6; Govind Persad et al., *Principles for Allocation of Scarce Medical Interventions*, 373 LANCET 423, 428–29 (2009), [http://econopundit.com/ezekiel\\_emmanuel.pdf](http://econopundit.com/ezekiel_emmanuel.pdf).

180. Thus, the resource distribution discussed in this paper, such as vaccine distribution, should be distinguished from the philosophy of wealth redistribution. Wealth redistribution is controversial because private actors who create wealth bear many individual risks, and many argue that wealth should not be distributed to those who have not borne similar risks. See, e.g., Culhane, *supra* note 179, at 177–78.

181. Culhane, *supra* note 179, at 177–78.

ethicists is that the burden of these risks should be shared by all members of society.<sup>182</sup>

*(1) The Threat of Medical Shortages*

Luckily, the 2009 vaccine shortage discussed in the introduction became a surplus within a few weeks, and the 2009 H1N1 epidemic was far less communicable and deadly than predicted.<sup>183</sup> Although disaster was averted, the world had already faced two other pandemic scares in the past decade, and scientists predict that it is only a matter of time until the next deadly pandemic strikes.<sup>184</sup> Worst-case scenarios point to the 1918 Spanish Influenza, which infected one-third of the global population of 1.8 billion, killing 20 to 50 million people worldwide and an estimated 675,000 Americans.<sup>185</sup>

Federal and state governments have undertaken extensive planning efforts and legislative enactments in preparation for the inevitable pandemic. Nonetheless, a congressional commission recently found that the United States is “seriously lacking” in its capability to provide resources including adequate

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182. See *supra* note 179. Notably, the application of distributive justice principles to mass casualty events (and organ allocation) does not stir the controversy that it does in application to healthcare resources, generally. See, e.g., CDC ETHICS SUBCOMMITTEE OF THE ADVISORY COMMITTEE, *supra* note 61; Samia A. Hurst et al., *Allocating Resources in Humanitarian Medicine*, 2 PUB. HEALTH ETHICS 89, 89–90 (2009); Persad et al., *supra* note 179. When it comes to “resource allocation decisions, protracted crises differ from acute crises in important ways.” Hurst et al., *supra*, at 90. One notable difference is the extreme scarcity of resources such as organs and potentially lifesaving care in a mass-casualty event. Persad et al., *supra* note 179. Perhaps another difference (especially in the mass casualty event) is based on “the rule of rescue, ‘the imperative people feel to rescue identifiable individuals facing avoidable death.’” Hurst et al., *supra*, at 89. The rule of rescue implies “that an identifiable, immediate victim should have priority over distant ‘statistical’ lives.” *Id.* The acute urgency of a pandemic and the pressing need of its immediately identifiable victims may thus more readily justify the argument that resources should be distributed to those victims without regard to their purchasing power.

183. See, e.g., Bryan Walsh, *5 Burning Questions About Swine Flu: How Deadly is H1N1?*, TIME.COM (May 25, 2009), [http://www.time.com/time/specials/packages/article/0,28804,1900559\\_1900558\\_1900540,00.html](http://www.time.com/time/specials/packages/article/0,28804,1900559_1900558_1900540,00.html).

184. Philip Hunter, *Inevitable or Avoidable? Despite the Lessons of History, the World is Not Yet Ready to Face the Next Great Plague*, 8 EUR. MOLECULAR BIOLOGY ORG. REP. 531–34 (2007); see also Albert Osterhaus, *Pre- or post-pandemic influenza vaccine?*, 25(27) VACCINE 4983, 4983–84 (2007) (“It is generally accepted that it is just a matter of time before . . . another [worldwide] pandemic outbreak of influenza.”). A pandemic could result from natural causes, or could also be the result of a bioterrorist attack, which the government estimates is more likely to occur than any other type of major terrorist attack. COMMISSION ON THE PREVENTION OF WEAPONS OF MASS DESTRUCTION PROLIFERATION AND TERRORISM, PREVENTION OF WMD PROLIFERATION AND TERRORISM REPORT CARD 1–2, 6 (2010) [hereinafter COMMISSION ON THE PREVENTION OF WEAPONS OF MASS DESTRUCTION].

185. Terrence M. Tumpey, *Characterization of the Reconstructed 1918 Spanish Influenza Pandemic Virus*, 310(5745) SCI. 77–80 (2005).

medical supplies, distribution methods, treatment, and preventive measures.<sup>186</sup> This was especially troubling since the virus was milder than predicted<sup>187</sup> and the country had months to prepare for H1N1—time that they would not have to prepare for a deadlier bioterrorist attack or pandemic with natural causes.<sup>188</sup>

The types of resources that will likely be in very short supply include vaccines, anti-viral drugs, personal protective equipment, hospital beds, ventilators, doctors, and healthcare workers.<sup>189</sup> Fortunately, because the H1N1 epidemic was relatively mild, the only major shortage that the American public experienced was the vaccine shortage; but, the shortage was glaring nonetheless.<sup>190</sup> In a deadly pandemic, we will most likely be faced with more than just a shortage of vaccines. For example, ventilators are an important medical resource which may be vital to save lives during a pandemic, but will likely be in very short supply.<sup>191</sup> Currently there are about 62,000 ventilators in the United States (plus some small emergency stockpiles),<sup>192</sup> but experts predict that anywhere from 163,000 to 750,000 people will need to be

186. COMMISSION ON THE PREVENTION OF WEAPONS OF MASS DESTRUCTION, *supra* note 184, at 6.

187. *See, e.g.*, Walsh, *supra* note 183.

188. COMMISSION ON THE PREVENTION OF WEAPONS OF MASS DESTRUCTION, *supra* note 184, at 2.

189. *See, e.g.*, COMMISSION ON THE PREVENTION OF WEAPONS OF MASS DESTRUCTION, *supra* note 184, at 2, 6 (U.S. is “seriously lacking” in ability to provide sufficient vaccines, countermeasures, treatment, hospital facilities, and more); CENTER FOR BIOSECURITY OF UPMC, *supra* note 176, at ii, 13–14 (estimating severe shortages in hospital and ICU beds and ventilators, and finding that “[a]ll medical care capacity will be overwhelmed, especially emergency departments and ICUs”); Richard D. Branson et al., *Surge Capacity Mechanical Ventilation*, 53(1) RESPIRATORY CARE 78, 78–79 (2008) (ventilator shortages); Mary Grace Keating Duley, *The Next Pandemic: Anticipating an Overwhelmed Health Care System*, 78 YALE J. BIOLOGY & MED. 351, 352, 355 (2005) (discussing how increased demand could overwhelm personnel even under normal circumstances, and that the problem could be exacerbated since available healthcare staff might be reduced due to illness); Charlene Irvin et al., *Hospital Personnel Response During a Hypothetical Influenza Pandemic: Will They Come to Work?*, ACAD. EMERGENCY MED. 14(5), Supp. 1 (May 2007) (“Personnel absenteeism during a pandemic due to fear of contracting an illness may result in significant personnel shortage and this issue should be addressed in pandemic disaster plans.”); Marcel Verweij, *Moral Principles for Allocating Scarce Medical Resources in an Influenza Pandemic*, 6(2) J. BIOETHICAL INQUIRY 159 (2009) (discussing predicted shortages in personal protective equipment, antiviral drugs, hospital beds, mechanical ventilation, vaccination, and more).

190. *See* COMMISSION ON THE PREVENTION OF WEAPONS OF MASS DESTRUCTION, *supra* note 184, at 2, 6; Elizabeth Landau, *Frustration Looms as H1N1 Vaccines Run Out*, CNN (Oct. 26, 2009), <http://www.cnn.com/2009/HEALTH/10/24/h1n1.vaccine.where/index.html?iref=allsearch>.

191. The need for ventilators is likely to outstrip capacity, potentially severely. Branson et al., *supra* note 189, at 78–79 (discussing how mass casualty respiratory failure will overwhelm the nation’s capacity for mechanical ventilation, resulting in unnecessary mortality).

192. *National Ventilator Survey: The Results Are In!*, AM. ASS’N FOR RESPIRATORY CARE (Feb. 10, 2010), <http://www.aarc.org/headlines/10/02/nvs.cfm> (comprehensive inventory of mechanical ventilators in every U.S. hospital, showed that 62,274 ventilators exist that could be used in a pandemic); Michael E. Hanley, *Mechanical Ventilation in Mass Casualty Scenarios. Augmenting Staff: Project XTREME*, 53(2) RESPIRATORY CARE 176, 177 (2008) (discussing small stockpiles of approximately 4,000 ventilators).

ventilated in a pandemic similar to the 1918 influenza.<sup>193</sup> Furthermore, intensive care unit (ICU) needs could exceed 364% of capacity.<sup>194</sup>

Researchers are working to diminish the impact of some predictable medical shortages,<sup>195</sup> but even in the unlikely event that some of these issues are quickly addressed,<sup>196</sup> the majority of predicted shortages may take years to address,<sup>197</sup> and there is still the threat that a previously unknown type of pandemic or bioterrorist attack may result in unforeseen shortages.<sup>198</sup>

## (2) *The Danger of “Playing God”*

When dialysis was a scarce medical resource, the Seattle Artificial Kidney Center set up what was later dubbed the “God Committee” to decide

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193. Unfortunately, the number of ventilators is just enough to deal with a regular flu season and could not begin to accommodate the far greater numbers that would be required during a pandemic. CENTER FOR BIOSECURITY OF UPMC, *supra* note 176, at 14 (estimating that 165,000 ventilators will be needed); Carol Daus, *Avian Flu Pandemic: Will We Be Prepared?*, RT FOR DECISION MAKERS IN RESPIRATORY CARE, Mar. 2007, [http://www.rtmagazine.com/issues/articles/2007-03\\_02.asp](http://www.rtmagazine.com/issues/articles/2007-03_02.asp) (estimating that as many as 750,000 ventilators could be needed); Michael Osterholm, *Preparing for the Next Pandemic*, 352(18) NEW ENG. J. MED. 1839 (2005).

194. CENTER FOR BIOSECURITY OF UPMC, *supra* note 176, at 13–14.

195. New cell-based vaccine technologies may be used to develop future influenza vaccines. Robert Roos, *Novartis Unveils US Cell-Based Flu Vaccine Plant*, THE CENTER FOR INFECTIOUS DISEASE RES. & POL’Y (Nov. 24, 2009), <http://www.cidrap.umn.edu/cidrap/content/influenza/swineflu/news/nov2409novartis.html>. Additionally, physicians have recently developed prototypes for a more-efficient, lower-cost ventilator that could be used during a pandemic. Wiley-Blackwell, *Doctors Develop Life-Saving, Low-Cost Ventilators for Emergency, Rural and Military Use*, SCI. DAILY (Jan. 25, 2010), <http://www.sciencedaily.com/releases/2010/01/100125094643.htm>.

196. For instance, even if vaccine production is improved using cell-based technology it may not be able to be developed and distributed as quickly as a virus could proliferate. The H1N1 vaccine took months to produce, and unfortunately new cell-culture technologies are only “somewhat” faster in speeding up vaccine production. Roos, *supra* note 195. Similarly, the government is working to increase the number of stockpiled ventilators for emergencies, but shortages will likely still be experienced in the case of a nationwide threat and that “[l]ittle is known about the success of mechanical-ventilator stockpiling for mass casualty respiratory failure.” Branson et al., *supra* note 189, at 78. Another problem is the availability of persons trained to operate the ventilators. *See generally* Hanley, *supra* note 192 (acknowledging that in the case of a nationwide crisis such as a pandemic or bioterrorist attack respiratory therapists from outside the regions will likely be unavailable, staff resources will be depleted by the event, and other than local volunteers, few resources will be available).

197. CENTER FOR BIOSECURITY OF UPMC, *supra* note 176, at 13–14, 33 (discussing the drastic resource shortages that will likely occur—especially in hospital capacity and personnel—and concluding that some improvements are possible, but will take “a number of years” to accomplish).

198. *See* Katz, *supra* note 57, at 799–801 (discussing the difficulty in predicting shortages, particularly in the event of a bioterrorist attack).

who should receive access.<sup>199</sup> Committee members considered a number of factors including net worth, past societal contributions, and future potential.<sup>200</sup>

Although the arbitrary and subjective allocation used by the “God Committee” has long since been eschewed by ethicists and the medical community, any allocation system will in essence be “Playing God” by determining who gets to receive scarce medical resources and live.<sup>201</sup> Since medical ethicists today agree that equality is important,<sup>202</sup> more recent organ allocation systems have attempted to set up objective systems by limiting criteria to more quantitative data such as matching blood antigens (kidneys) or time spent on the waiting list (livers).<sup>203</sup> However, both of these systems were abandoned because of their disparate impact on minorities: antigen-matching reduced the likelihood of a kidney transplant since antigens show differently in African Americans, and African Americans were much more likely to join the liver waiting list too late, likely due to less healthcare access.<sup>204</sup>

How should life-saving treatment be rationed in a pandemic? Governmental and medical authorities and ethicists have begun to grapple with this question<sup>205</sup> and largely agree that a first-come, first-served method will not work during a deadly pandemic or bioterrorist attack.<sup>206</sup> States, hospitals, and the CDC have begun developing guidelines for priority, triage, and even refusal of—or removal from—care.<sup>207</sup> Many plans anticipate that

199. Deirdre Fetherstonhaugh, *Dialysis: A paradigm case of rationing medical treatment*, 5(2) RENAL SOC. AUSTRALASIA J. 88, 88–89 (2009), [http://www.renalsociety.org/RSAJ/journal/RSA\\_july09.pdf#page=48](http://www.renalsociety.org/RSAJ/journal/RSA_july09.pdf#page=48).

200. *Id.* at 90.

201. See Charles I. Lugosi, *Playing God: Mary Must Die So Jodie May Live Longer*, 17 ISSUES L. & MED. 123 (2001) (discussing the decision to separate conjoined twins so that one might survive).

202. See *supra* notes 179–82 and accompanying text.

203. See *supra* notes 46–47, 51 and accompanying text (discussing blood-antigen matching system); Andrea E. Reid et al., *Disparity in Use of Orthotopic Liver Transplantation Among Blacks and Whites*, 10(7) LIVER TRANSPLANTATION 834 (2004) (discussing previous disparities in liver transplants); Carla K. Johnson, *Transplant Study Finds No Racial Gap*, VIRGINIAN-PILOT, Nov. 26, 2008, at A6; Dennis Peck, *System Eliminates Liver Transplant Disparity*, THE OREGONIAN, Nov. 25, 2008, [http://www.oregonlive.com/health/index.ssf/2008/11/system\\_elimimates\\_liver\\_transp.html](http://www.oregonlive.com/health/index.ssf/2008/11/system_elimimates_liver_transp.html) (discussing previous system for allocating donor livers).

204. See *supra* notes 46–47 (discussing changes made in kidney allocation); see also Peck, *supra* note 207 (discussing changes made in liver allocation).

205. See, e.g., Fink, *supra* note 89.

206. See, e.g., CDC VENTILATOR GUIDANCE WORKGROUP, *supra* note 88, at 8; CDC ETHICS SUBCOMM. OF THE ADVISORY COMM., *supra* note 61, at 7 (“[First-come, first-served] favours people . . . [with] wealth, power, and connections—to decide who receives scarce interventions, and is therefore practically flawed.”).

207. CDC VENTILATOR GUIDANCE WORKGROUP, *supra* note 88, at 8; CDC ETHICS SUBCOMM. OF

there will be a need not only to ration ventilator treatment and hospital beds, but to remove patients who are not improving, even without the consent of patients or their families.<sup>208</sup>

While equitable distribution of healthcare resources may normally be a controversial topic,<sup>209</sup> ethicists and authorities tend to agree that in a pandemic situation with very scarce resources and the looming threat of mass casualties, treatment should not be determined based on purchasing power.<sup>210</sup> This determination is consistent with organ allocation systems, which attempt to distribute scarce organs based on equitable criteria other than wealth.<sup>211</sup>

Thus, pandemic triage and allocation guidelines agree that resources should be distributed equitably, according to factors independent of wealth, although the specific prioritization criteria differ by state and hospital. For example, New York and Utah recommend regular assessment of each individual's likelihood of survival in determining whether they should be placed on or removed from ventilators,<sup>212</sup> while Florida's plan suggests a similar assessment for allowing hospital access focused on "providing the greatest good for the greatest number."<sup>213</sup> Other proposed frameworks include the life cycle principle (favoring younger people over older people), fair chances (using a lottery system to award treatment), and the "multiplier effect" (vaccinating healthcare workers who can then save other lives), life expectancy, quality of life, patients who will respond to treatment most rapidly, or some combination of the above methods.<sup>214</sup> The CDC has

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THE ADVISORY COMM., *supra* note 61, at 7; *see also* FLA. DEP'T OF HEALTH PANDEMIC INFLUENZA TECHNICAL ADVISORY COMM., PANDEMIC INFLUENZA: TRIAGE AND SCARCE RESOURCE ALLOCATION GUIDELINES (8th ver. 2009), [http://propublica.s3.amazonaws.com/assets/docs/ACS\\_GUIDE\\_Ver8.pdf](http://propublica.s3.amazonaws.com/assets/docs/ACS_GUIDE_Ver8.pdf); N.Y. STATE WORKGROUP ON VENTILATOR ALLOCATION, *supra* note 69; UTAH HOSP. & HEALTH SYS. ASS'N, UTAH PANDEMIC INFLUENZA HOSPITAL AND ICU TRIAGE GUIDELINES (2d ver. 2009), [http://www.uha-utah.org/Disaster%20Prep%20Materials/PANDEMIC%20FLU%20Triage%20Guidelines\\_081109.pdf](http://www.uha-utah.org/Disaster%20Prep%20Materials/PANDEMIC%20FLU%20Triage%20Guidelines_081109.pdf).

208. *See* CDC VENTILATOR GUIDANCE WORKGROUP, *supra* note 88, at 19–21; FLA. DEP'T OF HEALTH PANDEMIC INFLUENZA TECHNICAL ADVISORY COMM., *supra* note 207, at 5–8; N.Y. STATE WORKGROUP ON VENTILATOR ALLOCATION, *supra* note 69, at 17–18, 32–33, 35; UTAH HOSP. & HEALTH SYS. ASS'N, *supra* note 207, at 2, 4–7; Fink, *supra* note 89.

209. *See supra* notes 182, 184.

210. CDC ETHICS SUBCOMM. OF THE ADVISORY COMM., *supra* note 61, at 6–7. *See also supra* notes 184–86 and accompanying text.

211. *See* Persad et al., *supra* note 179, at 426–27 (discussing organ allocation systems).

212. N.Y. STATE WORKGROUP ON VENTILATOR ALLOCATION, *supra* note 69, at 17–18, 32–33, 35; UTAH HOSP. & HEALTH SYS. ASS'N, *supra* note 207, at 2, 4–7.

213. FLA. DEP'T OF HEALTH PANDEMIC INFLUENZA TECHNICAL ADVISORY COMM., *supra* note 207, at 1.

214. CDC VENTILATOR GUIDANCE WORKGROUP, *supra* note 88, at 13–15 (discusses "life cycle," "fair chances," and "multiplier effect," advocates combination); Persad et al., *supra* note 179, at 423–29 (discusses "life cycle," "fair chances," and "multiplier effect," quality of life, and other factors, and



recommended a different approach for prioritizing vaccine access than for prioritizing ventilator access. It recommends distributing vaccines according to people most at risk of death from the virus, as well as based on the “multiplier effect.”<sup>215</sup> For ventilator rationing, it recommends incorporating multiple principles to arrive at a composite priority score.<sup>216</sup> However, the CDC admits that its approach still “raises difficult questions regarding what principles should be represented in the composite score and how to weight the [score’s] various components[.]”<sup>217</sup>

The development of ethical guidelines and principles in rationing scarce medical resources is important to ensure predictability, maintain the public trust, and uphold the rule of law.<sup>218</sup> It is also the first line of defense against discrimination, increasing the likelihood of consistent application regardless of race or ethnicity.<sup>219</sup>

However, the danger is that some recommended guidelines, which appear and attempt to be facially neutral, may in effect inadvertently disfavor minority individuals. One example is that systems may fail to consider biological or genetic differences in minority individuals, such as when the kidney allocation system overlooked the fact that antigens show differently in African Americans.<sup>220</sup> However, by focusing on the needs of the majority, allocation systems may also fail to account for differences in health due to past healthcare access. This is an important nexus that may lead to further

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advocates combination); Mark S. Stein, *The Distribution of Life-Saving Medical Resources: Equality, Life Expectancy, and Choice Behind the Veil*, 19 SOC. PHIL. & POL’Y 212, no. 2, 2002 at 212, 212 (advocates life expectancy); Verweij, *supra* note 189, at 159 (suggests prioritizing patients who will benefit most within the shortest time).

215. CTRS. FOR DISEASE CONTROL & PREVENTION, *2009 H1N1 Vaccination Recommendations*, <http://www.cdc.gov/h1n1flu/vaccination/acip.htm> (last updated Oct. 15, 2009); *see also* Bridget M. Kuehn, *CDC Names H1N1 Vaccine Priority Groups*, 302(11) J. AM. MED. ASS’N 1157 (2009).

216. CDC VENTILATOR GUIDANCE WORKGROUP, *supra* note 88, at 15.

217. *Id.*

218. Annas et al., *supra* note 130, at 23 (noting that the rule of law depends upon the fair distribution of resources); Ramirez et al., *supra* note 27, at 1196 (people are less likely to cooperate with law enforcement when their practices “are perceived to be biased, unfair, [or] disrespectful”). Resource distribution methods that are transparent and equitable methods are necessary to ensure legitimacy. Persad et al., *supra* note 179, at 429.

219. Reducing “the opportunities for undetected bias to infect clinical decisions by limiting the amount of discretion afforded doctors in their treatment choices” may help reduce racial disparity. WANG, *DISCRIMINATION BY DEFAULT*, *supra* note 116, at 144. Guidelines focused on quantitative factors will help guard against discrimination. Wang, *supra* note 37, at 1108 (“[V]ariations that are not based on scientific evidence are the kind most likely to produce unwarranted racial disparity.”). *See also supra* notes 58, 129–32 and accompanying text.

220. *See supra* note 33.

inequities if ignored in planning for public health emergencies.<sup>221</sup> African Americans are twice as likely as white Americans to be uninsured, and Native American and Latino Americans are three times as whites likely to be uninsured.<sup>222</sup> For example, guidelines that factor in life expectancy may discriminate against African Americans who on average have lower life expectancies than European Americans.<sup>223</sup> Plans that assess likelihood of survival may inadvertently discriminate against minority individuals, who presented with far more serious and fatal cases of H1N1, perhaps due to less access to healthcare.<sup>224</sup> Similarly, the approach that simply seeks to save the most lives possible may tend to favor healthier people, who require fewer resources to save.<sup>225</sup> Should someone who is in worse health because she has lacked access to quality health care—or has been discriminated against in the past—be refused life-saving medical treatment? If the answer is yes, minorities will again be disproportionately affected.<sup>226</sup>

Thus, existing guidelines leave something to be desired in assuring that minority individuals are afforded an equal chance to receive rationed healthcare. Since a lottery system may be too complicated to administer, some argue a system that favors younger people over older people or that assesses multiple factors may be the most equitable.<sup>227</sup> However, adjusted guidelines alone—even if tested and shown to have an equitable impact—will not

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221. U.S. COMM’N ON CIVIL RIGHTS OFFICE OF CIVIL RIGHTS EVALUATION, BIOTERRORISM AND HEALTH CARE DISPARITIES (Mar. 8, 2002) (“Our review finds that the government does not have a plan to ensure that all groups, be they . . . ethnic, or racial, will receive prompt, sufficient, and systematic treatment following a biological attack . . . . An underlying weakness of the nation’s health care system is that it ignores the nexus between population group membership and the receipt of health care. Health care disparities exist between various population groups. Past failures to take disparities into account give rise to questions about the government’s readiness to treat all Americans if bioterrorism escalates.”), <http://www.usccr.gov/pubs/biotrbf/paper.htm>.

222. U.S. CENSUS BUREAU, INCOME, POVERTY AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2008 (2009), available at <http://www.census.gov/prod/2009pubs/p60-236.pdf>.

223. NAT’L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2008, at 203 (2008), <http://www.cdc.gov/nchs/data/abus/abus08.pdf#026>.

224. See Hennessy-Fiske, *supra* note 11.

225. Hoffman, *Preparing for Disaster*, *supra* note 6, at 1508–09 (“[T]he principle of utility might translate into a policy of attempting to save the greatest number of lives and thus to direct treatment to those who are most likely to benefit from it . . . [u]tilitarian principles might militate against prioritizing care for the disadvantaged in an emergency if such individuals would require a disproportionate amount of resources.”).

226. *Id.*

227. CDC VENTILATOR GUIDANCE WORKGROUP, *supra* note 88, at 15; Persad et al., *supra* note 179, at 428–29.

eliminate the threat of discrimination,<sup>228</sup> especially since already-existing tendencies to discriminate may be magnified by racial “scapegoating.”

*(3) Ad-Hoc Decision-Making and Reduced Transparency*

Minority groups might also disproportionately suffer the effects of shortages based on ad-hoc, disorganized or arbitrary macro-level distribution among hospitals and communities. Ad-hoc distribution systems could result in shortages that are far more severe in minority communities, especially given the possibility that a pandemic might prove far deadlier among minority groups than among European Americans.<sup>229</sup> As we learned all too well during Hurricane Katrina, availability of supplies will do nothing if adequate distribution methods are not in place.<sup>230</sup>

As discussed in the introduction, vaccine supply and distribution faced major challenges during the recent H1N1 epidemic.<sup>231</sup> The CDC coordinated vaccine orders, notifying the states as doses became available, and each state developed its own vaccine delivery plan.<sup>232</sup> Foreseeing shortages, the CDC prioritized high risk groups that should be first to receive the vaccine, including pregnant women, caregivers for children younger than six months, healthcare and emergency medical services personnel, children, and people aged 25 through 64 years old with certain health conditions.<sup>233</sup>

The issue that was not adequately addressed was *which* high risk individuals should receive vaccinations before others—an issue highlighted in the controversy surrounding the vaccine shipments to Wall Street banking corporations.<sup>234</sup> Although it does not appear that any intentional favoritism

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228. Just as disparities in kidney allocation were not eliminated when the system for allocation was adjusted for equity, *see supra* note 46, so equitable pandemic allocation guidelines will merely ensure that no institutionalized discrimination will occur (and good guidelines will guard against abuse), but physician discretion still allows for *unconscious* discrimination. *See* UTAH HOSP. & HEALTH SYS. ASS’N, *supra* note 207, at 1 (“Application of these guidelines will require physician judgment at the point of patient care.”).

229. *See supra* note 10 and accompanying text.

230. *See, e.g.*, CHRISTOPHER COOPER & ROBERT JEFFREY BLOCK, *DISASTER: HURRICANE KATRINA AND THE FAILURE OF HOMELAND SECURITY* 246–48 (2006); MICHAEL ERIC DYSON, *COME HELL OR HIGH WATER: HURRICANE KATRINA AND THE COLOR OF DISASTER* 136 (2006).

231. *See supra* notes 2–6 and accompanying text.

232. *See* CTRS. FOR DISEASE CONTROL & PREVENTION, *State/Jurisdiction Contact Information for Providers Interested in Providing H1N1 Vaccine*, Oct. 14, 2009, <http://www.cdc.gov/h1n1flu/vaccination/statecontacts.htm>; Elizabeth Landau, *As First Vaccines Go Out, H1N1 Questions Answered*, CNN, Oct. 7, 2009, [http://articles.cnn.com/2009-10-06/health/h1n1.vaccine.questions\\_1\\_swine-flu-vaccine-priority-groups-intranasal-vaccine?\\_s=PM:HEALTH](http://articles.cnn.com/2009-10-06/health/h1n1.vaccine.questions_1_swine-flu-vaccine-priority-groups-intranasal-vaccine?_s=PM:HEALTH).

233. *See supra* note 215.

234. *See supra* notes 2–6, and accompanying text.

was shown, the hurried and confused distribution process resulted in a situation where high-risk individuals associated with a powerful bank were better able to obtain vaccinations than high risk individuals who had no such connections. Similarly, early data shows that underserved areas received a disproportionate share of vaccines in L.A. County.<sup>235</sup> With the potential for abuse evident, more research should be done to determine how better distribution systems can guard against any institutional discrimination that might be caused by disproportionate distribution, as well as remove any room for discretion or discrimination.<sup>236</sup>

Furthermore, regardless of what allocation or prioritization systems are put in place, some level of discretion will inevitably be required of physicians at the micro-level and of distribution centers at the macro-level. Where there is discretion, there is room for overt and subconscious discrimination, especially if there is a lack of accountability to the public.<sup>237</sup> Thus, overwhelmed hospital and distribution center staffs and hurried decision-making may further exacerbate the problem by reducing the likelihood of accountability and transparency.

### III. DOUSING THE FLAMES: MEASURES THAT MIGHT OFFSET REDUCED LEGAL SAFEGUARDS

A *laissez-faire* approach to discrimination during a pandemic is hardly appropriate given the government's interventionist role in pandemic response.<sup>238</sup> During a pandemic, emergency response action by the government will reduce legal safeguards against inadvertent discrimination, barring minority groups to all but intentional discrimination claims, which are notoriously difficult to prove.<sup>239</sup> Additionally, the government has indicated that it will intervene in the healthcare system through methods including distribution of emergency resources, recommending guidelines for triage and

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235. See, e.g., Hennessy-Fiske, *supra* note 11.

236. See *supra* notes 58, 129–32, 219.

237. *Id.*

238. See, e.g., Dayna Bowen Matthew, *Disastrous Disasters: Restoring Civil Rights Protections for Victims of the State in Natural Disasters*, 2 J. HEALTH & BIOMEDICAL L. 213, 214–15 (2006) (Explaining that government should be responsible for its role in heightening ethnic and racial disparities during natural disasters, the author states that: “[N]atural disasters magnify the Government’s contribution to public health disparities so that they are easy to identify and examine. . . .” And “because of the centrality of the Government’s responsibility to manage the impact of natural disasters, these crises allow for a focus on the legal solutions available to address government sponsored public health discrimination.”).

239. See, e.g., *supra* note 134.

rationing, deploying military personnel, control of health supplies and facilities, and response organization.<sup>240</sup>

This section argues that under the authority of its obligation to ensure that no one is denied equal protection of the laws, the government should replace the safeguards it will be lifting with other protections against discrimination. The best way to do so may be to allow plaintiffs to simply prove that they were disparately impacted rather than requiring them to prove that the discrimination was intentional. Legal advocates can also explore methods of challenging current pandemic plans that may result in inequity. They can also press for additional legislation to protect racial and ethnic minorities and to increase the level of transparency and accountability in the distribution of pandemic resources and response.

*A. Create a Disparate Impact Remedy That Will Apply During Pandemic Emergencies*

Providing a disparate impact remedy against racial or ethnic discrimination during a pandemic may help to counteract the reductions of other legal safeguards against discrimination. Although remedies may sound reactionary rather preventive by nature, the disparate impact doctrine was engineered not only to provide *post-facto* remedies, but to encourage providers to prevent discrimination by addressing potential problems in a prophylactic way.<sup>241</sup> As one scholar explains, the origins of disparate impact doctrine lie “in

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240. TURNING POINT, MODEL STATE PUBLIC HEALTH ACT 24–26, 33, 36, 41–45 (2003), <http://www.hss.state.ak.us/dph/improving/turningpoint/PDFs/MSPHAweb.pdf> (model act with language adopted by numerous states includes provisions authorizing control of and access to facilities, control of and distribution of health care supplies, mandating treatment, coordinate response, and more); CENTER FOR LAW & PUBLIC HEALTH, THE TURNING POINT MODEL STATE PUBLIC HEALTH ACT: STATE LEGISLATIVE UPDATE TABLE (2007) (as of 2007, twenty-six states had passed at least some portion of the Turning Point Model State Public Health Act), <http://www.publichealthlaw.net/Resources/ResourcesPDFs/MSPHA%20LegisTrack.pdf>; JAMES E. BAKER, IN THE COMMON DEFENSE: NATIONAL SECURITY LAW FOR PERILOUS TIMES 286–90 (2007) (discussing the government’s role in bioterrorism and pandemic planning and coordination); *id.* (DHS has power to distribute Strategic National Stockpile resources); Hanley, *supra* note 192, at 178–80 (personnel from military, the National Disaster Medical System, the United States Public Health Service, and volunteer registration systems will likely be deployed to assist onsite at hospitals and healthcare centers).

241. Susan D. Carle, *A Social Movement History of Title VII Disparate Impact Analysis*, 63 FLA. L. REV. 251, 255–58, 295–97 (2011) (discussing the dual roles of disparate impact as a tool to both shape employers practices, and win cases); *id.* at 295 (the idea was “to soft-pedal change . . . but also carry[] the ‘stick’ of potential lawsuits to command employers’ attention.” See also, e.g., Claude Platten, *Title VII Disparate Impact Suits Against State Governments After Hibbs and Lane*, 55 DUKE L.J. 641, 643, 664–75 (2005) (discussing the validity of congressional authority to pass disparate impact legislation in order to

a pro-business, regulatory-partnership model embraced by moderate civil rights leaders. Activists . . . envisioned using law to engineer social change, not primarily by resorting to the courts, but rather by encouraging employers to reflect on and take action suited to their situations.”<sup>242</sup> Thus, Congress should consider passing a statute that will permit discrimination claims in a pandemic situation to be brought based on a disparate impact analysis. Rather than being required to prove discriminatory intent,<sup>243</sup> plaintiffs would simply have to show that pandemic-related resources were disproportionately distributed to minority individuals or groups. Not only would the remedy reduce the burden of proof required to prove discrimination, but it would provide an additional safeguard by alerting healthcare providers and emergency responders that they will be held accountable for the fair distribution of resources, regardless of their intent.

Disparate impact claims are already permitted in employment, housing, lending, and voting.<sup>244</sup> Like the special circumstances in these arenas, Congress should recognize that the circumstances surrounding a pandemic call for increased protection, especially given government’s active role in reducing other safeguards.<sup>245</sup>

The cause of action for a disparate impact claim regarding pandemic response could be similar to the elements of disparate impact claims recognized in other areas of the law.<sup>246</sup> In order to prove a *prima facie* case of disparate impact, a plaintiff would have to show that a distribution plan, prioritization guidelines, or emergency response had a disparate impact on

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prophylactically prevent the infringement of rights); *id.* at 652 (“[T]he primary purpose of the disparate impact theory is to remove barriers to employment opportunity that disproportionately burden women or racial or ethnic minorities. It is available to challenge both objective employment standards, such as standardized tests, and also subjective practices, such as job interviews, in which supervisors’ exercise of discretion has a disparate impact.”).

242. Carle, *supra* note 241, at 295.

243. Currently, Title VI and the Equal Protection clause require proof of intent. Laufer, *supra* note 116, at 1614.

244. Laufer, *supra* note 116, at 1648 (employment); *City of Cuyahoga Falls, Ohio v. Buckeye Cmty. Hope Found.*, 538 U.S. 188, 199–200 (2003) (Fair Housing Act); *Osborne v. Bank of Am., Nat. Ass’n*, 234 F. Supp. 2d 804, 811 (M.D. Tenn. 2002) (Equal Credit Opportunity Act); *Rome v. United States*, 446 U.S. 156 (1980) (voting).

245. Others have recommended that disparate impact claims should be permitted in healthcare generally, even without the level of government intervention that will be involved in a pandemic. *See, e.g.*, Pittman, *supra* note 33, at 180–85.

246. *See, e.g.*, Ann B. Lever & Todd Espinosa, *A Tale of Two Fair Housing Disparate-Impact Cases*, 15 J. AFFORDABLE HOUSING & COMMUNITY DEV. L. 257, 258 (2006) (discussing the *prima facie* case under the Fair Housing Act). *See also, e.g.*, Platten, *supra* note 241, at 653 (discussing the *prima facie* case in employment cases under Title VII).

minorities. The burden would then shift to the defendant to prove that the disparate impact was justifiable, and also to disprove any claim made by the plaintiff that another less-discriminatory alternative was available.

At first glance it might seem that provision of a disparate impact remedy could open the door too wide and add confusion to a system that will likely be overwhelmed during a pandemic. However, this solution is not likely to destabilize emergency response. Although proof of intent is not required, disparate impact claims are still difficult to prove and not widely used.<sup>247</sup> Nonetheless, lack of use does not diminish the potential effect of a disparate impact remedy in safeguarding against discrimination.<sup>248</sup> The disparate impact doctrine has played an important role in addressing employment discrimination, although few cases go to court or succeed.<sup>249</sup> The remedy is considered by many to be particularly useful because of its preventive effects.<sup>250</sup> “[T]he force of disparate impact law ultimately lies, not merely in litigation victories, but also in shaping employers’ incentives.”<sup>251</sup> Lawyers counsel employers to self-scrutinize their practices and, historically, “the threat of being hauled into court helped motivate employers to cooperate with . . . suggestions to assess and overhaul traditional employment practices.”<sup>252</sup> Although *during* a pandemic situation, healthcare should arguably be focused primarily on saving lives rather than on future lawsuits, the knowledge that the disparate impact remedy will apply during a pandemic will likely incentivize healthcare providers now, *prior to* a pandemic, to scrutinize and adapt their pandemic planning and emergency response procedures to prevent disparate impact.

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247. Carle, *supra* note 241, at 257; Elaine W. Shoben, *Disparate Impact Theory in Employment Discrimination: What’s Griggs Still Good For? What Not?*, 42 BRANDEIS L.J. 597, 607 (2004).

248. Carle, *supra* note 241, at 255–58, 295–97. Allowing a disparate impact remedy can provide a measured way of reasonably reducing discrimination through careful preventive planning, without creating too drastic of a liability burden that might be difficult for courts and healthcare providers to deal with in an emergency. *See id.* at 299 (noting that the Court’s approach to disparate impact doctrine in employment seems “consistent with early civil rights activists’ experimentalist views . . . that law should offer standards and guidance about good civil rights practices, along with fairly low probabilities of liability.” The thinking seems to be that “[t]his w[ill] lead employers to take some steps to lower liability concerns . . . but not to take unduly drastic measures . . . to insulate themselves from a litigation threat set too high.”).

249. Carle, *supra* note 241, at 255–58, 295–97 (discussing the important role disparate impact theory has played in the fight against employment discrimination); *id.* at 257 (discussing the difficulty in succeeding under disparate impact theories); Shoben, *supra* note 247, at 607 (discussing the underutilization of the theory).

250. Carle, *supra* note 241.

251. *Id.* at 296.

252. *Id.*

Allowing disparate impact claims may even increase trust in emergency responders and in the rule of law.<sup>253</sup> Furthermore, cases that go to trial will likely be less costly and complex to litigate than cases involving questions of consent.<sup>254</sup> A disparate impact approach would have the additional benefit of reducing blame, since no one would be scrutinized for malicious intent,<sup>255</sup> and punitive damages would likely be unavailable.<sup>256</sup> Attention would be placed on the object of the action rather than the morality of the actor. This focus will be especially relevant during a pandemic, when solving the problem will be more important than pinning the blame on public servants and emergency responders who may have made bad decisions under immense pressure.

*B. Explore Legal Advocacy and Litigation Regarding Current Pandemic Planning*

Legal advocates should look for ways to address the reduction of legal safeguards and the potential disparities *before* a pandemic strikes. For example, advocates could explore the availability (or creation) of injunctive remedies to challenge existing emergency plans which they believe will have an inequitable impact on racial or ethnic minorities should a pandemic strike. The City of Los Angeles was recently found liable under the Americans with Disabilities Act (ADA) for not adequately preparing for the needs of persons with disabilities in the city's emergency disaster planning.<sup>257</sup> Although the ADA and the needs of persons with disabilities clearly raise distinctly different issues and legal remedies, the case demonstrates the potential for proactively and preventatively challenging emergency response plans and the legal issues and inequities such plans might create.

In the context of racial and ethnic discrimination, preventive claims would undoubtedly face obstacles such as standing and ripeness. However, to the extent that emergency planning programs might be shown to inequitably impact racial and ethnic minorities, these obstacles might prove

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253. See *supra* note 218; *infra* note 268.

254. *Rogers v. Lodge*, 458 U.S. 613, 645–48 (1982) (Stevens, J., dissenting) (discussing the costs and complexities associated with litigating questions of intent in discrimination cases).

255. The availability of disparate impact claims arguably focuses people on “the benefits of encouraging employer rationality and fairness in employment practices” rather than on retroactive investigations into retroactive investigations into malintent. See Carle, *supra* note 241, at 258.

256. See Shoben, *supra* note 247, at 598.

257. *Communities Actively Living Indep. and Free v. City of Los Angeles*, No. CV 09-0287 CBM (RZx), 2011 WL 4595993 at \*\*5-17 (C.D. Cal. Feb. 20, 2011).



surmountable.<sup>258</sup> The creation of disparate impact claims would make it easier to challenge pandemic planning and guidelines that might prove inequitable, since disparate impact claims can generally be brought based on existing policies or objective standards and criteria (such as standardized tests in the employment field).<sup>259</sup> Absent the availability of disparate impact claims, however, other legal advocacy options should nonetheless be explored.<sup>260</sup>

### *C. Create Structural Support for Legal Advocacy and Disparate Impact Claims*

During a pandemic, the potential risk of increased racial and ethnic discrimination and the concurrent reduction of legal safeguards against such discrimination create a threat too real to ignore. At a time when they may be desperately needed, protections must be put in place to counteract the effects of governmentally reduced legal safeguards.

Legal advocates should press for abrogating immunity in disparate impact claims specific to pandemic response, providing for due process hearings, and mandating increased transparency. Additionally, the CDC or Department of Health and Human Services (DHHS) should test rationing procedures for disparate impact, and provide training on the dangers of discrimination in a pandemic.

#### *(1) Waive, Abrogate, or Deny Immunity*

Congress should add the availability of disparate impact claims to existing bodies of emergency law, allowing for compensatory damages as well as injunctive relief.<sup>261</sup> In the statute(s) creating disparate impact remedies for emergencies, Congress should consider waiving federal immunity, abrogating

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258. In the ADA challenge, the City's emergency planning was considered an existing governmental program, therefore permitting claims to be brought against the program itself, regardless of the fact no actual emergency had taken place. *See id.* at 23.

259. *See, e.g.,* Platton, *supra* note 241, at 652 ("[T]he primary purpose of the disparate impact theory is to remove barriers to employment opportunity that disproportionately burden women or racial or ethnic minorities. It is available to challenge both objective employment standards, such as standardized tests, and also subjective practices, such as job interviews, in which supervisors' exercise of discretion has a disparate impact.").

260. For example, one scholar has suggested a detailed litigation strategy to address inequity in disaster response, claiming misuse of government funding under the Civil False Claim's Act's *qui tam* provision. Matthew, *supra* note 238, at 233–34.

261. *See supra* Part III.A.

state immunity,<sup>262</sup> and denying immunity to individuals and organizations that would otherwise be granted immunity during a pandemic response. Immunity will likely be important to emergency response since healthcare providers cannot be expected to uphold normal standards of care during a pandemic, and expanded immunities will likely be important to increase healthcare workers' and volunteers' response.<sup>263</sup> However, there should be a way to allow for general immunity while recognizing that disparate treatment and discrimination (including unconscious and institutional discrimination) should not be tolerated under any circumstances.<sup>264</sup>

*(2) Provide Hearings, Perhaps Through an Administrative Board*

Currently, CDC emergency planning guidelines that anticipate removing people from life-sustaining treatment in order to give others a chance plan to give notice to the patient and their family, but do not explicitly plan for some type of hearing to be granted.<sup>265</sup> Similarly, state plans fail to mention whether patients will have any opportunity to have their case be heard. Although internal triage officers or panels are sometimes anticipated, it is not clear whether the person will actually get a hearing, or whether decisions may be appealed. The government should consider plans that would allow hearings to take place, especially hearings for claims of discrimination. For example, options could include allowing these decisions to be appealed, especially if they involve discrimination claims, or perhaps setting up an administrative review board similar to the EEOC. A viable plan to allow hearings, especially with claims of discrimination, is important not only in the interest of justice, but to bring legitimacy when the rule of law may be destabilized and precarious at best.<sup>266</sup>

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262. Under § 5 of the Fourteenth Amendment, Congress has the power to abrogate state sovereign immunity where states have failed to address discrimination against a protected and historically disadvantaged class. *Nevada Dept. of Human Resources v. Hibbs*, 538 U.S. 721, 726, 734–37 (2003). However, it must “make[] its intention to abrogate unmistakably clear in the language of the statute. . . .” *Id.* at 726.

263. See Hoffman, *supra* note 118, at 1917–18.

264. This principle is well-recognized in international law, which generally states that even when states have the right to derogate from certain rights during times of national emergency, the right to non-discrimination is non-derogable, meaning that it should never be rescinded. See, e.g., International Covenant on Civil and Political Rights art. 4, Dec. 16, 1966, S. Treaty Doc. No. 95-20, 999 U.N.T.S. 171; see also Inter-American Commission on Human Rights, *Report on Terrorism and Human Rights* ¶¶ 343, 410, 412 (2002), available at <http://www.cidh.org/Terrorism/Eng/toc.htm>.

265. See *supra* notes 105–08 and accompanying text.

266. Gostin, *supra* note 62, at 1166 (“Procedural due process also is important to public acceptance

### *(3) Plan for Increased Transparency*

Information and demographic data on all resources that have been distributed, denied, or withdrawn, must be recorded and available. Tracking this data will help to keep healthcare officials cognizant and accountable.<sup>267</sup> Additionally, any disparate impact will be visible to the public and to individuals who may use the data to get preliminary injunctions on a disparate impact claim (if such a claim is made available). Finally, making such information transparent and available will likely have the added impact of increasing citizens' trust in the process and rule of law.<sup>268</sup>

Additionally, to guard against the potential of supply chain abuse or misuse to disproportionately deprive minority groups of access to vaccine or other medical resources, transparent and accountable distribution plans should be developed and made public for comment prior to the onset of an epidemic. Well-connected individuals should not disproportionately benefit from hurried or disorganized supply chain management.<sup>269</sup>

### *(4) Conduct Testing on Recommended Rationing Procedures and Point Systems*

The original liver and kidney distribution systems demonstrate that when rationing systems are designed with the majority in mind or with a focus on saving the most lives possible, differences are ignored or overlooked, and the system has a detrimental and disparate impact on minority groups. Recommended guidelines should be tested for disparate impact on minority groups, and appropriately adjusted. Some guidelines give vague recommendations, which should be specified sufficiently so that they may be

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of the legitimacy of the governmental action. The public is more likely to agree to liberty-limiting powers if there is recourse for challenging those that are perceived as unjust.”).

267. See WANG, DISCRIMINATION BY DEFAULT, *supra* note 116, at 143–44 (“Data collection would compel institutions to ‘think about race,’” and increase the likelihood that decisions will be made based on accurate judgments, rather than confirmed predictions.); Hoffman, *Preparing for Disaster*, *supra* note 6, at 1540–46 (recommending enhanced accountability and detailed emergency planning guidance to counteract the potentially devastating impacts of disasters on vulnerable populations). See also *supra* notes 58, 127–32, 219.

268. Annas et al., *supra* note 130, at 37 (“In order to obtain the support of the public for any rationing scheme, it must be developed prior to a pandemic, have broad public input, be reasonable, and be subject to revision as new information is obtained.”). See also *supra* note 218.

269. See *supra* notes 230–36.

tested. Testing results could be made available to the public to increase their confidence in the system and the rule of law.

*(5) Provide Training on Disparate Impact and the Dangers of Discrimination in a Pandemic*

Additionally, potential emergency responders should be trained regarding the dangers of increased discrimination when resources are scarce, fear and discretion are increased, and laws are changed. When people are aware of the circumstances under which they might tend to inadvertently discriminate, it is easier for them to avoid doing so.<sup>270</sup> People are also less likely to discriminate when they are aware that they will be held accountable,<sup>271</sup> so responders should also be made aware that to compensate for reduced legal safeguards against discrimination in a pandemic, the government will prohibit systems or conduct that result in a disparate impact on minorities. They should also understand that data and demographic information will be recorded and available to the public.

#### IV. CONCLUSION

During a pandemic, reduced legal safeguards against racial and ethnic discrimination, combined with resource shortages, ad-hoc decision-making, the potential for racial scapegoating, and the problem of discrimination in healthcare, could add up to a disastrous situation for our country's minority

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270. Individuals "are more likely to act (albeit unconsciously) upon stereotypes of racial minorities when they are not (consciously) confronted with potential biases and preconceptions they may hold of racial minorities." Andrew W. Bribiesco, *Latino/a Plaintiffs and the Intersection of Stereotypes, Unconscious Bias, Race-Neutral Policies, and Personal Injury*, 13 J. GENDER RACE & JUST. 373 (2010) (citing Dana E. Mastro et al., *Exposure to Television Portrayals of Latinos: The Implications of Aversive Racism and Social Identity Theory*, 34 HUM. COMM. RES. 1, 17 (2008)). See also Kerry Kawakami, *Kicking the Habit: Effects of Nonstereotypic Association Training and Correction Processes on Hiring Decisions*, 41 J. EXPERIMENTAL SOC. PSYCHOLOGY 68, 68 (2005) ("training can reduce the uncontrolled activation of stereotypes"); Linda Hamilton Krieger, *The Content of Our Categories: A Cognitive Bias Approach to Discrimination and Equal Employment Opportunity*, 47 STAN. L. REV. 1161, 1167, 1213–14 ("Equipped with conscious self-awareness, well-intentioned employers become capable of complying with the law's proscriptive injunction not to discriminate. They will monitor their decision-making processes and prevent prohibited factors from affecting their judgments.").

271. The effects of unconscious biases "can be minimized when judgments are based on timely and relevant information; when decision makers evaluate that information consistently with respect to clearly articulated criteria; and when a mechanism exists for holding decision makers accountable for the process they have used and criteria they have applied in making their judgments." Bielby, *supra* note 131, at 124. See also *supra* notes 58, 129–32, 219.

citizens. We cannot afford to let a chaotic situation, infused with fear, to so disparately and disproportionately burden minority communities.

Legal advocates and federal, state, and local governments should act quickly so that if and when a pandemic or bioterrorist attack strikes, protections will be in place to ensure that the impact of discrimination on minority communities does not rise to a level even greater than normal due to governmental reduction of safeguards. It may be acceptable to allow greater restrictions on everyone's individual rights, but it should never be acceptable to permit more discrimination against a few.